

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9420

## CERTIFICATE OF DEATH

11772

Reg. Dist. No. 440

## 1. PLACE OF DEATH

County Balto.  
 City or town Chase  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Turn River Beach Rd. Bv 73

How long in hospital or institution?

5 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.  
 City or town Chase  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Turn River Beach Rd. Bv 73  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Alice Virgin Baker.

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Edward Newton (deceased)

7. Birth date of

deceased (mo., day, yr.)

Sept 18 1892

6.(c) If alive, give age..... years

8. AGE:

54

Years

7

Months

29

Days

If less than one day

hrs.

min.

9. Birthplace

Glyndon, Balto Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

own home

FATHER

12. Name

Andrew F. Bowers

13. Birthplace

Glyndon, Md

MOTHER

14. Maiden name

Annie B. Boublitz

15. Birthplace

John Baker

16. Informant

Address

Chase, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

12/20/46

Cemetery or crematory

Asbury M. E. Cemetery

Location

Reisterstown, Md.

18. Funeral director

Howard N. Blight Jr.

Address

4914 Belair Road

19. Dec. 18 46

(Date rec'd by registrar)

C. W. Haddick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1946 at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 17 1946 to Dec 17 1946

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Crowning occlusion in 50mm.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

Dr. Mearns M.D.Address Dunkirk, Mo. Date signed 1/17/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11773

Reg. Dist. No. 400

### 1. PLACE OF DEATH

County Baltimore  
City or town Jacksonville Md  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution Sweet Air Road  
Stay in hospital or inst. (yrs., or mos., or days) 16 yrs  
Stay in this community (yrs., or mos., or days) 16 yrs

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)  
State Maryland County Baltimore  
City or town Jacksonville Ward No.   
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. Sweet Air Road  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR

### 3. (a) FULL NAME

Elwood Henry Banister

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Dorothy G. V. T. T.  
(c) If alive, give age  years

7. Birth date of deceased (mo., day, yr.) JUNE 12 - 1886  
8. AGE: Years 60 Months 6 Days 8 If less than one day  hrs.  min.

9. Birthplace Harford Co. Md  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Geoffrey Banister  
13. Birthplace Md.

MOTHER 14. Maiden name Bertie Burkeys  
15. Birthplace Md.

16. Informant Russell Banister  
Address 9600 Harford Rd

17. Burial Date thereof 12/23/46  
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Sherwood Cem  
Location Jacksonville, Md.

18. Funeral director Leonard Blum  
Address 5305 Harford Rd

19. 12/23 46 Edw. Hedych  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 19 46 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw alive on 19

Immediate cause of death Chronic heart disease, with coronary occlusion  
Due to

Due to

Other conditions Right inguinal hernia

(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Rollin G. Hudson M.D. P.M.E.  
Address Towson Md Date signed 12/20/46

### DURATION

12/20/46

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

PLEASE WRITE PLAINLY WITH UNFADING INK. Simply every item of information carefully. The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

Registered No.

380

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland *Pa. Railroad Tracks*  
 (b) Street address *Luthersville Md.*  
 (c) Hospital or institution:  
 (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md* (b) County *Baltimore*  
 (c) City or town *Luthersville*  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. *Seminary Ave.*  
 (If rural give location)  
 (e) Citizen of foreign country? *No* (Yea or No)  
 If yes, name country

## 3 (a) FULL NAME

*David Bernard Barrett*

## 3 (b) If veteran, name war

## 3 (c) Social Security Account

No. *217-07-9757*

## 4. Sex

*Male*

## 5. Color or race

*White*

## 6 (a) Single, married, widowed, or divorced.

*Single*

## 6 (b) Name of husband or wife

## 6 (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

*Aug. 8, 1905*

## 8. AGE: Years

*41*

## Months

*4*

## Days

*7*

## less than one day

*- hr. - min.*

## 9. Birthplace

*Towson, Balt. Co., Md.*  
(Town, county, and state)

## 10. Usual Occupation

*Carpenter*

## 11. Industry or business

*General Trade*

## FATHER

## 12. Name

*Michael Barrett*

## 13. Birthplace

*Ireland*

## MOTHER

## 14. Maiden Name

*Margaret*

## 15. Birthplace

*Balt. Md.*

## 16 (a) Informant

*Mrs. John Forde, Jr.*

## (b) Address

*Luthersville, Md.*17 (a) *Burial*

(Burial, cremation, or removal)

## (b) Date thereof

*Dec. 18, 1946*  
(month) (day) (year)

## (c) Cemetery or crematory

*St. Maria Cem.*

## Location

*Towson, Maryland*

## 18 (a) Funeral director

*John Burke Sons*

## (b) Address

*Towson, Md.*

## 19 (a)

## (b)

(Date rec'd by registrar)

*A. W. Hearn* Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 15, 1946*, at *7:50 A.M.*

21. I certify that I took charge of the remains described above, held an *Inspection & Inquiry* thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

## IMMEDIATE CAUSE OF DEATH

*Occupation*  
*Mutilation (Traumatic)*Due to *Eviction*

## Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *12-15-46* at *4 A.M.*(b) Where did injury occur? *Pa. R.R. - Luthersville Md.*(c) Did injury occur at home, on farm, industrial place, in public place? *public* While at work? *no*(d) Means of injury *Struck by R.R. Train*23. Signature *Howard J. Wheeler* M.D.Date signed *12-16-46* Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11775 381  
Reg. Dist. No.

1. PLACE OF DEATH:  
County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 year, 14 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 1 year, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Upperco  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Estie M. Becker

## 3.(b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Edward Becker  
7. Birth date of deceased (mo., day, yr.) February 8, 1891 6.(c) If alive, give age 60 years

8. AGE: Years 55 Months 10 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace York County, Pennsylvania  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name George Dubbs

13. Birthplace Pennsylvania

14. Maiden name Minnie Prezzle

15. Birthplace Pennsylvania

16. Informant Hospital records

Address Catonsville-28, Md.

17. Burial Data thereof Dec. 16, 1946  
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory York Road Cemetery

Location Harford Co.

18. Funeral director J. A. Hesser

Address Harford Co.

19. Dec. 13th 19 46 Harry D. Muller  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 19 46 at 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 28 19 45 to December 12 19 46

and that I last saw her alive on December 12 19 46

Immediate cause of death Chronic left coronary artery disease DURATION indef.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Atrophy of right kidney " "

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Harry D. Muller M.D. or other \_\_\_\_\_

Address Catonsville-28, Md. Date signed 12-13-46



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DEC 16 1946  
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1-35

2-3-10 7-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

## CERTIFICATE OF DEATH

11776

Reg. Dist. No. 301

1. PLACE OF DEATH: Baltimore  
County Catonsville  
City or town (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 months, 11 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 8 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
Maryland  
State County  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1615 Hakesley Court  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Alice Bell

### 3. (b) Social Security Number

4. Sex f 5. Color or race W 6.(a) Single, married, widowed, or divorced single  
6.(b) Name of husband or wife -  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) August 3, 1867  
8. AGE: Years 79 Months 4 Days 10 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)  
10. Usual occupation seamstress  
11. Industry or business home  
FATHER 12. Name Walter Bell  
13. Birthplace Virginia  
MOTHER 14. Maiden name Mary Muller  
15. Birthplace Pennsylvania

16. Informant Hospital Records  
Address Catonsville 28, Md.  
17. (Burial, cremation, or removal) Which? Date thereof 1/3/47  
(month) (day) (year)  
Cemetary or crematory Baltimore  
Location Baltimore, Md.  
18. Funeral director William C. Mead  
Address 1219 1/2 Paul St.  
19. 1-3 15-35  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1946 at 3:45 a.m.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1946 to December 13 1946  
and that I last saw him alive on December 13 1946

Immediate cause of death Acute myocardial insufficiency  
DURATION 1 week  
Due to Chronic arteriosclerotic cardiovascular renal disease Indef.  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results As above.  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Henry C. A. Mead, M.D. M. D. or other  
Address Catonsville 28, Md. Date signed 12/13/46

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

11777

★ Reg. Dist. No. 32

### 1. PLACE OF DEATH:

County Baltimore  
City or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 0 yrs., 0 mos., 1 day  
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
How long in hospital or institution? 0 yrs., 0 mos., 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 222 Clarendon Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Mrs. Clara Emma Berkemeier

### 3. (b) Social Security Number

# Unknown

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mr. Calvin Berkemeier  
6. (c) If alive, give age Unknown

7. Birth date of deceased (mo., day, yr.) June 14, 1910

8. AGE: Years 36 Months 5 Days 26 If less than one day  
..... hrs. .... min.

9. Birthplace Parkton, Maryland  
(town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Harry Thompson

13. Birthplace Baltimore Co., Maryland

MOTHER 14. Maiden name Laura Kemp

15. Birthplace Baltimore Co., Maryland

16. Informant Mr. Calvin C. Berkemeier

Address 222 Clarendon Ave., Pikesville, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec. 12, 1946  
(month) (day) (year)

Cemetery or crematory Druid Ridge Cemetery

Location Pikesville, Maryland

18. Funeral director Frank Newell

Address Pikesville, Maryland

19. 12/10/46 19 46 Earl W. Webster  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1946 at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9, 1946 to Dec. 10, 1946 and that I last saw her alive on December 10, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 11 yrs.

Due to Tubercle Bacilli

Due to

Other conditions Tuberculous Enteritis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations No operation

..... Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M.D. or other

Address Mount Wilson, Md. Date signed 12/10/46

Rec'd - 12-12-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 13 1946

BUREAU V 8

1-25

2-320-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11778

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 hours 5 minutes  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Fort Howard, Maryland  
 How long in hospital or institution? 22 hours 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 809 S. Charles St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW-2 ✓

## 3. (a) FULL NAME

CHARLES W. BLACKWELL

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife Lucille Blackwell  
 6. (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) March 5, 1921

8. AGE: Years 25 Months 9 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Social Circle, Ga.  
 (Town, county, and state)

10. Usual occupation House Painter

## 11. Industry or business

FATHER 12. Name Henry Blackwell

13. Birthplace North Carolina

MOTHER 14. Maiden name Onie Wigley

15. Birthplace Athens, Ga.

16. Informant Clinical Records Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial, cremation, or removal. Which? Burial Date 12/18/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lancaster

Location Lancaster - South Carolina

18. Funeral director Eggenworth Armistead

Address 3911 Liberty Heights Ave.

19. (Date rec'd by registrar) 12/16/46 Registrar Dr. H. H. H.

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1946 at 10:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14, 1946 to December 15, 1946

and that I last saw him alive on December 15, 1946

Immediate cause of death Phosphorous poisoning DURATION 2 days

Due to Phosphorous in rat poison paste

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Compatible with phosphorous poisoning

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 12-13-46

Where did injury occur? Baltimore, Maryland  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Self Inflicted Injured at work? no

By taking rat poison

23. SIGNATURE Dr. H. H. H. M. D. or other

Address 1711 1746 Date signed 12/18/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change  
of age is shown on  
G 108 2/3/47

## MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (6)

Reg. Dist. No. 441

## CERTIFICATE OF DEATH

11779

## 1. PLACE OF DEATH:

(a) County B. Balt.  
(b) City or town Chesapeake Pk.  
(If outside city or town limits, write RURAL and give town)  
(c) Street address, hospital, or institution: Bataspaw ave.  
(d) Length of stay in hospital or inst. (yrs., mos., or days)  
(e) Length of stay in this community (yrs., mos., or days)

## 2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State md (b) County Balto.  
(c) City or town Chesapeake Pk.  
(If outside city or town limits, write RURAL and give town)  
(d) Street No. Bataspaw ave.  
(If rural give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

## 3 (a) FULL NAME

William Conrad Booz

## 3 (b) If veteran, name war

## 3 (c) Social Security

No.

## 4. Sex

M

## 5. Color or race

W

## 6 (a) Single, married, widowed, or divorced.

married

## 6 (b) Name of husband or wife

Mary E. nee  
Hubert.

## 6 (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

Sept. 20 - 1886

## 8. AGE:

Years

Months

Days

If less than one day

61

hr.

min.

## 9. Birthplace

Balto.

(Town, county, and state)

## 10. Usual occupation

Merchant

## 11. Industry or business

FATHER

## 12. Name

Thomas J. Booz

## 13. Birthplace

Balto.

MOTHER

## 14. Maiden Name

Louise Barry

## 15. Birthplace

Balto.

## 16 (a) Informant

Mrs. A. J. Schaefer Jr.

## (b) Address

9343 Old Phil. Ad.

## 17 (a)

Burial

(Burial, cremation, or removal)

## (b) Date thereof

12/18/46

(month) (day) (year)

## (c) Cemetery or crematory

Sacred Heart

## Location

Gregory Hill Rd.

## 18 (a) Funeral director

John J. Connolly

## (b) Address

418 Eastern Ave. Ste. 4119 (a) 12/16/46

## (b)

John J. Connolly

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. Date of death Dec 14 1946, at 6:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1946, to Dec 14 1946, and that I last saw him alive on Dec 14 1946.

## Immediate cause of death

Coronary  
Thrombosis

## Duration

Sudden

## Due to

Atherosclerotic Cardis

## Due to

Vascular Disease

## Due to

Diabetes mellitus

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings:

Of operations

Of autopsy

## PHYSICIAN

Underline the cause to which death should be charged statistically.

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place? \_\_\_\_\_ While at work? \_\_\_\_\_

(Specify type of place)

(e) Means of injury

## 23. Signature

Geo. M. Baumgardner

M. D. or other

Address Balto 6 mdDate signed 12-14-46

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2-440 — 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

## CERTIFICATE OF DEATH

Reg. Dist. No. 310

## 1. PLACE OF DEATH:

County BaltimoreCity or town Villa Nova  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 5 Months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Villa Nova  
(If outside city or town limits, write RURAL and give nearest town)Street No. -----  
(If rural, give LOCATION)2(a) If veteran, name war -----

## 3. (a) FULL NAME

Fannie T. Bowen

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife John W. Bowen7. Birth date of deceased (mo., day, yr.) September 18, 18678. AGE: Years 79 Months 2 Days 24 If less than one day  
----- hrs. ----- min.9. Birthplace Harford County, Md.  
(Town, county, and state)10. Usual occupation None11. Industry or business -----FATHER 12. Name Jeremiah Yellott13. Birthplace MarylandMOTHER 14. Maiden name Alice Fendall15. Birthplace Maryland16. Informant Mrs. Elizabeth M. MurrayAddress 206 W. Monument Street17. Burial Date thereof 12/14/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Pikesville, Md.18. Funeral director W. W. Meeks and SonAddress 805 N. Calvert Street19. 12/13 46 A. W. Hedrick  
(Date rec'd by registrar) (Age) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 19 46, at 2 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 - 1942 to Dec 12 - 1946and that I last saw him alive on Oct 18 - 1946Immediate cause of death Cerebral hemorrhageDue to AtherosclerosisDue to -----Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----Date of op. -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE Chas. Hedrick M. D. or otherAddress 206 W. Monument St. Date signed 12/13/46

11780

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11781

420

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town 1219 Francis Ave - Huntly  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yearsHospital, institution, or street address where death occurred: ✓How long in hospital or institution? ✓

## 3. (a) FULL NAME

Simon Bransky

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## B. (b) Name of husband or wife

Bessie BranskyB. (c) If alive, give age 65 years

## 7. Birth date of

deceased (mo., day, yr.)

March 15 - 1861

## 8. AGE:

Years

85

Months

9

Days

5

If less than one day

— hrs. — min.

## 9. Birthplace

Russia

(Town, county, and state)

## 10. Usual occupation

Seafarer

## 11. Industry or business

Tobacco

## FATHER

## 12. Name

Unknown

## 13. Birthplace

"

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

"

## 16. Informant

Mrs Bessie Bransky

## Address

1219 Francis Ave

## 17. Burial

(Burial, cremation, or removal, Which?)

## Date thereof

12-22-46

(month) (day) (year)

## Cemetery or crematory

Balto Helms

## Location

Belair Rd

## 18. Funeral director

Jack Lewis Inc

## Address

1439 E Balto St.

## 19. Date rec'd by registrar

1-2-47

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

## State

Md.

## County

Baltimore

## City or town

Huntly

(If outside city or town limits, write RURAL and give nearest town)

## Street No.

1219 Francis Ave

(If rural, give LOCATION)

## 2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 19 46, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 20 19 46and that I last saw him alive on Dec 20 19 46Immediate cause of death Coronary decompensation DURATIONEdema 1 mo.Gravitate failureDue to Chronic myo. cardiacarterio sclerosis + yearsDue to arterio sclerosis

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ✓

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of ✓

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Frederic V. Beiter

M. D. or other

Address 723 Medical Arts Bldg - Balt Date signed 12-20-46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11782

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Fort Howard, Md.  
 How long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1310 Andre St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war SAW

## 3. (a) FULL NAME

COLLIS M. BRINK

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) September 21, 1878

8. AGE: Years 68 Months 2 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Spears, Kentucky  
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown

16. Informant Clin. Rec. Vets. Adm. Hospital  
 Address Fort Howard, Maryland

17. Burial Date thereof \_\_\_\_\_ (month) (day) (year)  
 (Burial, cremation, or removal. Which?)

Cemetery or crematory Cedar Hill CemeteryLocation Annapolis Rd., Balto., Md.18. Funeral director William Cook, Inc.Address 1217 St. Paul St., Balto., Md.

19. Dec. 11 19 46 R. M. Cullison  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 19 46 at 8:10A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5, 19 46 to December 10 19 46  
 and that I last saw him alive on December 10 19 46

Immediate cause of death MESENTERIC THROMBOSIS DURATION 4 days

Due to

Other Conditions: Old Rheumatic Fever, Mitral Valve Insufficiency, Arteriosclerosis of Coronary Arteries  
 Other conditions Calcification of Aortic Valves with Stenosis and Insufficiency. Unknown  
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. M. Cullison M. D. or otherAddress VAH FT. HOWARD MD. Date signed 12-10-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

 11783  
 Reg. Dist. No. 301

<b>1. PLACE OF DEATH:</b> County <u>Baltimore</u> City or town <u>Catonville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>237 Bloomsbury Ave</u> How long in hospital or institution? <u>Life</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Md.</u> County <u>Baltimore</u> City or town <u>Catonville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>237 Bloomsbury Ave</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Joseph Swift Browne</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>male</u> <b>5. Color or race</b> <u>white</u> <b>6. (a) Single, married, widowed, or divorced</b> <u>married</u> <b>6. (b) Name of husband or wife</b> <u>Mrs. Lasse</u> <b>7. Birth date of deceased (mo., day, yr.)</b> <u>April 3 1880</u> <b>8. (c) If alive, give age</b> years <b>8. AGE:</b> Years <u>66</u> Months <u>8</u> Days <u>0</u> If less than one day hrs. min. <b>9. Birthplace</b> <u>Lexington Va</u> (Town, county, and state) <b>10. Usual occupation</b> <u>Retired</u> <b>11. Industry or business</b>				<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>Dec 3</u> 19 <u>46</u> at <u>11 A.</u> M <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Mar</u> 19 <u>44</u> , to <u>Dec 3</u> 19 <u>46</u> , and that I last saw him alive on <u>Nov 27</u> 19 <u>46</u> . <b>Immediate cause of death</b> <u>Cerebral thrombosis</u> <b>Due to</b> <u>hypertension</u> <u>arterio-sclerosis</u> <b>Other conditions</b> (Include pregnancy within 3 months of death) <b>Major findings of operations</b> <b>Autopsy results</b> <b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.			
<b>FATHER</b> <b>12. Name</b> <u>Joseph Swift Brown</u> <b>13. Birthplace</b> <u>Child. Pa.</u> <b>MOTHER</b> <b>14. Maiden name</b> <u>Farley Cortin</u> <b>15. Birthplace</b> <u>Va.</u>				<b>DURATION</b> <u>Insult</u> <u>Gradual</u>			
<b>16. Informant</b> <u>Mrs. M. Lasse Browne</u> <b>Address</b> <u>237 Bloomsbury Ave</u> <b>17. Burial</b> <u>Burial</u> Date thereof <u>Dec 6 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) <b>Cemetery or crematory</b> <u>London Park Ave</u> <b>Location</b> <u>Baltimore Md</u>				<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: <b>Accident, suicide, or homicide</b> Date of <b>Where did injury occur?</b> (City or town) (County) (State) <b>Injured at home, farm, industry, public place (where?)</b> <b>Means of injury</b> <u>None</u> <b>Injured at work?</b>			
<b>18. Funeral director</b> <u>Henry M. Perkins Son &amp; Co</u> <b>Address</b> <u>McClure Dupard St</u> <b>19. 12-5- <u>46</u> <u>Harry L. Kullw</u>          (Date rec'd by registrar) (year) (month) (day) Registrar       </b>				<b>23. SIGNATURE</b> <u>W. H. Hardy</u> M. D. or other <b>Address</b> <u>1403 Park Ave</u> <b>Date signed</b> <u>12/4/46</u>			

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

## CERTIFICATE OF DEATH

Reg. Dist. No. 11784 340

<b>1. PLACE OF DEATH:</b> County <u>Baltimore</u> City or town <u>Upperoo</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>20 years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?			<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Upperoo</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war		
<b>3. (a) FULL NAME</b> <u>A. Vernon Bucher</u>			<b>3. (b) Social Security Number</b>		
<b>4. Sex</b> <u>M</u>	<b>5. Color or race</b> <u>W</u>	<b>6. (a) Single, married, widowed, or divorced</b> <u>M</u>			
<b>8. (b) Name of husband or wife</b> <u>Ellie G Wilder</u>					
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Apr 21-1898</u>					
<b>8. AGE:</b> Years <u>48</u> Months <u>7</u> Days <u>15</u> If less than one day _____ hrs. _____ min.					
<b>9. Birthplace</b> <u>Maryland</u> (Town, county, and state)					
<b>10. Usual occupation</b> <u>Plumber</u>					
<b>11. Industry or business</b>					
<b>12. Name</b> <u>David M Bucher</u>					
<b>13. Birthplace</b> <u>MD</u>					
<b>14. Maiden name</b> <u>Effie M Crowther</u>					
<b>15. Birthplace</b> <u>MD</u>					
<b>16. Informant</b> <u>Mrs A. Vernon Bucher</u> Address <u>Upperoo MD</u>					
<b>17. (Burial, cremation, or removal, Which?)</b> <u>Burial</u> Date thereof <u>Dec 9/46</u> (month) (day) (year) Cemetery or crematory <u>St Paul's</u> Location <u>Balto CO</u>					
<b>18. Funeral director</b> <u>Edw Chipton</u> Address <u>Hampstead Md</u>					
<b>19. (Date rec'd by registrar)</b> <u>Dec 8</u> 19 <u>46</u> <u>Cecil E Fowke MD</u> Registrar					
<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>6 December</u> 19 <u>46</u> , at <u>11:48 PM</u> <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>2 Sept</u> 19 <u>46</u> , to <u>6 Dec</u> 19 <u>46</u> and that I last saw him <u>alive</u> on <u>6 Dec</u> 19 <u>46</u> <b>Immediate cause of death</b> <u>Carcinoma Right Lung</u> <b>DURATION</b> <u>12 mo.</u> Due to _____ Due to _____ Other conditions _____ (Include pregnancy within 8 months of death) Major findings of operations _____ Date of op. _____ Autopsy results _____ <b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically. <b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____ <b>23. SIGNATURE</b> <u>N. F. Ernscher MD</u> M. D. or other Address <u>22 Hanover Rd, Reisterstown, Md.</u> Date signed <u>7 Dec 46</u>					

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. DECEASED'S NAME AND RESIDENCE

2. PLACE OF DEATH

3. DATE OF DEATH

4. MEDICAL CERTIFICATION

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11785

Reg. Dist. No. 11-20

<b>1. PLACE OF DEATH:</b> County..... <u>Baltimore</u> City or town..... <u>Relay</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>5 months and 7 days</u> Hospital, institution, or street address where death occurred: <u>Relay Sanatorium</u> How long in hospital or institution?..... <u>5 months and 7 days</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Hartford</u> City or town..... <u>Chesapeake</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>George F. Burkley</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widowed</u>			
<b>6. (b) Name of husband or wife</b> <u>Catherine Lay</u>				<b>6. (c) If alive, give age</b> ..... years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Feb. 14 - 1868</u>				<b>8. AGE:</b> Years <u>78</u> Months <u>11</u> Days <u>17</u> If less than one day ..... hrs. .... min.			
<b>9. Birthplace</b> <u>Hartford County, Maryland</u> (Town, county and state)				<b>10. Usual occupation</b> <u>Farmer</u>			
<b>11. Industry or business</b>				<b>12. Name</b> <u>J. Frederick Burkley</u>			
<b>13. Birthplace</b> <u>Germany</u>				<b>14. Maiden name</b> <u>Mrs. E. Burkley</u>			
<b>15. Birthplace</b> <u>Germany</u>				<b>16. Informant</b> <u>John E. Gentry</u> Address <u>Chesapeake Md</u>			
<b>17. Burial</b> (Burial, cremation, or removal. Which?) Cemetery or crematory..... <u>St. Paul Lutheran</u> Location..... <u>Chesapeake Md</u>				Date thereof..... <u>Dec 31 - 1946</u> (month) (day) (year)			
<b>18. Funeral director</b> <u>Henry Tanning Jones</u> Address <u>Chesapeake Md</u>				<b>19. Date rec'd by registrar</b> <u>Dec 29 46</u>			
<b>20. DATE OF DEATH</b> <u>Dec 29<sup>th</sup></u> 19 <u>46</u> at <u>2:00</u> A. M.				<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>July 22</u> 19 <u>46</u> to <u>Dec 27</u> 19 <u>46</u> and that I last saw him alive on <u>Dec 25</u> 19 <u>46</u> .			
<b>Immediate cause of death</b> <u>Cerebral hemorrhage</u>				<b>DURATION</b> <u>One week</u>			
<b>Due to</b> <u>Cerebral arteriosclerosis</u>				<u>Several years</u>			
<b>Due to</b> .....							
<b>Other conditions</b> .....							
(Include pregnancy within 3 months of death)							
<b>Major findings of operations</b> .....							
Date of op. ....							
<b>Autopsy results</b> .....							
<b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.							
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:							
Accident, suicide, or homicide..... Date of .....							
Where did injury occur? ..... (City or town) ..... (County) ..... (State)							
Injured at home, farm, industry, public place (where?) .....							
Means of injury ..... Injured at work? .....							
<b>23. SIGNATURE</b> <u>Genie P. Burkley</u> M. D. or other Address <u>Relay 27 2nd</u> Date signed <u>12/29/46</u>							

Registrar



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (922)

## CERTIFICATE OF DEATH

11786

Reg. Dist. No. 300

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Recedo Knoll

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1403 John street  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

MARY CATHERINE BURROWS

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife ----

7. Birth date of deceased (mo., day, yr.) April 24, 1861  
 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 85 Months 8 Days - It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Richmond, Va.  
 (Town, county, and state)

10. Usual occupation At home

## 11. Industry or business

12. Name Charles Burrows  
 13. Birthplace Ireland

14. Maiden name Ann McShane  
 15. Birthplace Ireland

16. Informant \_\_\_\_\_  
 Address \_\_\_\_\_

17. Burial Date thereof Dec. 27, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cathedral

Location Off the edge of Rd. Baltimore, D.C.

18. Funeral director Chas. J. Evans & Son, Inc.

Address 115 N. Mt. Royal Ave. Balt., Md.

19. Dec. 29 19 46  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 19 46 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 19 46  
 and that I last saw him alive on Dec 10, 19 46

Immediate cause of death \_\_\_\_\_

Arterio Sclerosis DURATION Long  
Chronic talenar heart Man  
disease 24

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

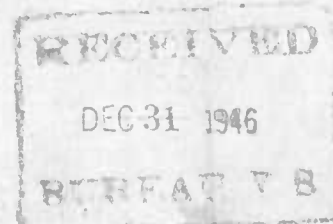
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Harrell H. Sumner  
 M. D. or other

Address Catonsville Rd Date signed 12/24/46

Dr. Carl Monmonier  
Edmondson avenue at Oakdale ave.  
Cat. 196



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

## 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5501 Edmondson avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5501 Edmondson avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

LILLIE MAY BURTON

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife Clifford Burton

6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, year) May 20, 1871

## 8. AGE:

Years

75

Months

6

Days

14

It less than one day

..... hrs. .... min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

12. Name John A. Chamberlain13. Birthplace Balto. Md.14. Maiden name Rebecca Mitchell15. Birthplace Balto. Md.16. Informant Miss Margaret M. SmithAddress 118 W. Mount Royal avenue17. Burial Date thereof 12/7/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location

18. Funeral director Chas. J. Evans & Son, Inc.Address 118 W. Mt. Royal Ave.19. Dec 6 19 46

(Date rec'd by registrar)

C. W. Hedrick  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 19 46 at 8A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 19 46 to Dec 4 19 46and that I last saw him..... alive on Dec 3 19 46

Immediate cause of death

Renal vascular thrombosis

DURATION

2 daysDue to arterio sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Catonsville Date signed 12/5

Dr. James G. Howell  
715 Frederick avenue

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 371

## 1. PLACE OF DEATH.

County BaltimoreCity or town Cecla, Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town .....  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

William Edward Carlin

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife Mary J. Carlin7. Birth date of deceased (mo., day, yr.) Nov 12 1876 6. (c) If alive, give age ..... years8. AGE: Years 70 Months 1 Days 17 If less than one day ..... hrs. .... min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation retired11. Industry or business Road foreman12. Name William H. Carlin13. Birthplace ?14. Maiden name ?15. Birthplace ?16. Informant Pierre F. CarlinAddress 615 Restave Baco17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 1/2/47  
(month) (day) (year)Cemetery or crematory St Johns CemeteryLocation Cecla City Md18. Funeral director Edna J. MacGableAddress Catonsville Md19. Date rec'd by registrar Jan 1st 1947 Registrar Shirley H. Kelly

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1946 at 1 45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-28 1946 to 12-29 1946 and that I last saw him alive on 12-28 1946Immediate cause of death Arteriosclerotic Vascular Disease DURATION 5 years  
Cerebral hemorrhage 24 hours

Due to .....

Due to .....

Other conditions Pneumonia of left side 8 years

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

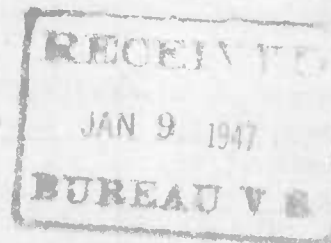
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE George E. Burdette M.D. M. D. or otherAddress Elliot City, Md. Date signed 12-29-46





2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11789

Reg. Dist. No. 330

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs  
 Hospital, institution, or street address where death occurred:  
Reisterstown Rd Owings Mills  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Baltimore  
 City or town Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Reisterstown Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war No

## 3. (a) FULL NAME

Henry Edwin Morrell Coomes

## 3. (b) Social Security Number

No

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M  
 6. (b) Name of husband or wife Azeline Post Coomes  
 6. (c) If alive, give age 77 years  
 7. Birth date of deceased (mo., day, yr.) April 29 1864  
 8. AGE: Years 82 Months 8 Days - If less than one day  
 ..... hrs. .... min.

9. Birthplace Longmeadow Mass  
 (Town, county, and state)  
 10. Usual occupation Retired manufacturer iron gates  
 11. Industry or business -

FATHER 12. Name Oliver B Coomes  
 13. Birthplace Mass  
 MOTHER 14. Maiden name Laura Morrell  
 15. Birthplace Cincinnati Ohio

16. Informant Mabel Louise Lamengo  
 Address Owings Mills Md

17. Burial Dec 31 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Springfield Cemetery  
 Location Elmont Long Island NY

18. Funeral director Wm Berryman & Sons  
 Address Reisterstown Md

19. Dec-30-1946 Mary B. Eline  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/46 19 46 at 2:30 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-45 to 12/29/46  
 and that I last saw H. E. M. alive on 12/29/46 19 46  
 Immediate cause of death Myocarditis - chronic  
decompensatory  
 Due to Hodgkin disease  
 Due to ostatic obstruction  
 Other conditions arteriosclerotic -  
general  
 (Include pregnancy within 3 months of death)

## DURATION

2 yrs  
2 yrs

Major findings of operations ✓

..... Date of op. ✓

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of 12/29/46  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE J. L. Saffell  
Reisterstown Md M. D. or other  
 Address..... Date signed 12/30/46

RECEIVED  
JAN 2 1947  
BUREAU OF  
1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93

## CERTIFICATE OF DEATH

11790

Reg. Dist. No.

35T

## 1. PLACE OF DEATH

County

City or town

Street address, hospital, or institution

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Ward No.

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h

Immediate cause of death

Due to

Due to

Other conditions

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1947

BUREAU

1-25

2-350-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

11791

Reg. Dist. No. 320

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Pikeville 8 md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
112 Clarendon Ave. Pikeville  
md.  
 How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Pikeville 8 Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 112 Clarendon Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Benjamin Franklin Cover Jr.

## 3. (b) Social Security Number

220-12-8243

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MWM6. (b) Name of husband or wife Alice K. Cover6. (c) If alive, give age 59 years7. Birth date of deceased (mo., day, yr.) May 6, 18848. AGE: Years Months Days If less than one day  
62 7 8 hrs. min.9. Birthplace Baltimore, md.  
(Town, county, and state)10. Usual occupation Assembler11. Industry or business Cases for food products12. Name Benjamin Franklin Cover13. Birthplace Baltimore, md.14. Maiden name Catherine Diggs15. Birthplace Baltimore, md.16. Informant Wife md.Address 112 Clarendon Ave, Pikeville17. BURIAL Date thereof 12-18-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WOODLAWN CEM.Location WOODLAWN, MD.18. Funeral director W. J. TICNER & SONS INC.Address NORTH PA. AVE. BALTO. 17, MD.19. Dec. 16 19 46 C. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 14 December 19 46 at 11:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Nov 10 19 46 to Dec. 14 19 46  
and that I last saw him alive on Dec. 14 19 46

Immediate cause of death

Coronary thrombosis

DURATION

Due to

arteriosclerosis

Due to

Other conditions

1. Nephritis  
2. Diabetes Mellitus  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Williams M.D.Pikeville, md. M. D. or otherAddress 1331 Reisterstown Rd. Date signed 14 Dec. 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

## CERTIFICATE OF DEATH

Reg. Dist. No. 11792 401

## 1. PLACE OF DEATH:

County Balto  
 City or town Glen Arm  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto  
 City or town Glen Arm (Bavali)  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Mary Ann Crow

## 3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced W

Theodore H Crow (Aug 15 1861)  
 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 15 1861  
 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 85 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hartford Co  
 (Town, county, and state)

10. Usual occupation Retired

## 11. Industry or business

12. Name John Dunnigan  
 13. Birthplace MD

14. Maiden name Anna Clark  
 15. Birthplace Pa

16. Informant Francis J Crow  
 Address Glen Arm

17. Burial Date thereof Dec 9 / 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Ignatius  
 Location Hickory MD

18. Funeral director Dean & Sister  
 Address Bel Air, Md

19. Dec 7 19 46 G. E. Anthony  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1946 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16 1946 to Dec 6 1946

and that I last saw him alive on December 6 1946

Immediate cause of death Pneumonia DURATION 24 hrs

Atherosclerotic Heart Disease 7 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Psychosis with cerebral arteriosclerosis 5 MOS

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Clifford F. Anderson M. D. or other \_\_\_\_\_

Address Fork, Md Date signed 12/7/46

RECEIVED

DEC 12 1946

BUREAU V &

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42-6)

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

11793

381

## 1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Rural Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Mercy Villa

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... New Jersey County.....City or town..... Atlantic City  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Margaret J. Cummings

## 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

FemaleWhiteSingle

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 8. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.  
About 859. Birthplace..... Maryland  
(Town, county, and state)10. Usual occupation..... None11. Industry or business..... None12. Name..... John Cummings13. Birthplace..... Ireland14. Maiden name..... Ellen E. Gorman15. Birthplace..... Maryland16. Informant..... Mrs. Phyllis C. MahoneyAddress..... 1402 Park Ave.17. Burial..... Date thereof..... 12/7/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery..... New CathedralLocation..... Baltimore18. Funeral director..... W. W. Meeks and SonAddress..... 805 N. Calvert St.19. 12-6-46 (Date rec'd by registrar) 20. D. W. Hately Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 5 19... 46 .. at... 2 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/4 19... 46 .. to... 12/4 19... 46 ..and that I last saw him... alive on... 12/4/46 19... 46 ..

Immediate cause of death.....

Family

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Charles R. Giesbrecht M.D.Address..... 2923 St Paul St Date signed..... 12/15/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 834

## CERTIFICATE OF DEATH

11794

Reg. Dist. No. 381

### 1. PLACE OF DEATH:

County Balto. Co.  
City or town Anneslie  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: 510 Overbrook Road  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) \_\_\_\_\_

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Balto  
City or town \_\_\_\_\_ Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 510 Overbrook Road  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Emma Jane Curran

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

B (b) Name of husband or wife H. J. Curran

6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 21 1857

8. AGE: Years 89 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Louisville Ky  
(Town, county, and state)

### 10. Usual occupation

11. Industry or business None

12. Name Charles J. McMill

13. Birthplace Chila Pa

14. Maiden name Marie O'Brien

15. Birthplace Springtown Pa

16. Informant Charles J. Curran

Address 510 Overbrook Road

17. Burial Date thereof Dec 4 1946  
(Burial, cremation, or removal. Which)

Cemetery or crematory St Louis Cem

Location Louisville Ky

18. Funeral director John A. Moran

Address 3000 E Baltimore St

19. 12/3 1946 A. J. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1946 at 6:45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1937 to December 2 1946  
and that I last saw her alive on December 2 1946

### Immediate cause of death

Right Hemiplegia

Due to Arteriosclerosis (Sclerosis)

Essential Hypertension

### Due to

Other conditions Pericarditis

(Include pregnancy within 3 months of death)

### Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. Grafton Thompson M. D. or other

Address 214 Medical Bldg Date signed 12/3/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-25- 2-580-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

11795

Reg. Dist. No. 372

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1st years  
 Hospital, institution, or street address where death occurred:  
Impronic Home, Cockeysville Md  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 318 Augusta Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs Ella Pauline Davis

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Marcus Mitchell Davis  
 8. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 6th - 1864  
 8. AGE: Years 82 Months 8 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore Md  
 (Town, county, and state)  
 10. Usual occupation Reg. Nurse  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Henry Vaughan  
 13. Birthplace St. Marys Co.  
 14. Maiden name Elizabeth Roberts  
 15. Birthplace Baltimore Md

16. Informant Laura M. Schroeder  
 Address Impronic Home, Cockeysville Md  
 17. Burial Date thereof Dec 18 - 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Gruid Ridge  
 Location # 250

18. Funeral director Wm. Cook  
 Address St. Paul & Preston St,  
Dec 17 19 46 L. M. Schroeder  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 19 46 at 9:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 24 19 46 to Dec 15 19 46  
 and that I last saw her alive on Dec 15th 19 46

Immediate cause of death \_\_\_\_\_ DURATION  
Cardiac Decompensation 3 days  
 Due to \_\_\_\_\_  
Generalized Arteriosclerosis 5 yrs?  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

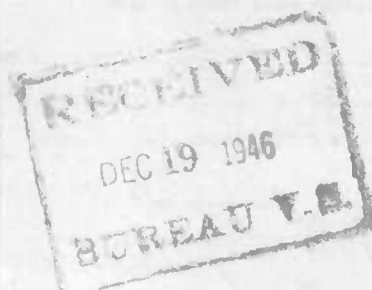
(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter J. Kees M.D.  
Cockeysville Md M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 12/15/46



1-25

2-370 - 1-10



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11796

Reg. Dist. No. 400

### 1. PLACE OF DEATH:

County Baltimore

City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Dundalk

City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6907 Dummerway  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

Emma C Hoppenberg Dreisbach

### 3. (b) Social Security Number

4. Sex F 5. Color or race White 6. (a) Single, married, widowed or divorced widow

6. (b) Name of husband or wife Laurence Dreisbach

7. Birth date of deceased (mo., day, yr.) July 5 1876 6. (c) If alive, give age years

8. AGE: Years 70 Months 5 Days 14 If less than one day hrs. min.

9. Birthplace Ohio  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Gertrude Hoppenberg

13. Birthplace Ger

14. Maiden name Pauline Matthes

15. Birthplace Ger

16. Informant Herbert P Dreisbach

Address 6907 Dummerway

17. Cremation Date thereof Dec 21/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dorndon Park

Location Balto Md

18. Funeral director Welch Funeral Home

Address 2008 Orleans St

19. Dec 21 1946 Dreisbach  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19<sup>th</sup> 1946 at 11:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1946, to Dec. 1946  
and that I last saw him alive on Dec. 19 1946

Immediate cause of death Carcinoma of left breast & lymph nodes  
Due to metastatic cancer

DURATION  
2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? Baltimore (City or town) Baltimore (County) Md (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE W B Davis M.D.

Address Dundalk - Md M. D. or other MD  
Date signed 12/21/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11797

Reg. Dist. No. 410

## 1. PLACE OF DEATH

County Balto.  
City or town Dundalk.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yearsHospital, institution, or street address where death occurred: 6806 Dundalk Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6806 Dundalk Rd.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Elisha Jones Ebersole

## 3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife Alice B. Ebersole

6. (c) If alive, give age..... year

7. Birth date of deceased (mo., day, yr.) Nov 5/18648. AGE: Year 82 Months 1 Day 1 If less than one day

hrs. min.

9. Birthplace Parkton, Md.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Joshua Baker13. Birthplace Baltimore, Co.

14. Maiden name

15. Birthplace

16. Informant Mrs. Va. BakerAddress 1801 Dundalk Rd. Dundalk, Md.17. Burial Date thereof Dec. 9, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. ZionLocation Freeland, Balto. Co., Md.18. Funeral director Roland L. FisherAddress 2112 Dundalk Ave.19. 12/7/46 Wm. C. ...

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 6 1946 to Dec 6 1946

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Cerebral HemorrhageDURATION Instant

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE Wm. C. ...Address Dundalk, Md.Date signed 12/7/46

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1179

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Ft. Howard, Maryland  
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 612 Scott Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW-I

## 3. (a) FULL NAME

GEORGE JOHN ERBE

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife Divorced  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) December 1, 1896  
 8. AGE: Years 50 Months 0 Days 12  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation Painter

11. Industry or business \_\_\_\_\_

FATHER 12. Name George Erbe  
 13. Birthplace Germany

MOTHER 14. Maiden name Marie Fluegel  
 15. Birthplace Germany

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Fort Howard, Maryland

17. Burial Burial Date thereof Dec 17-1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery  
 Location 5501 Frederick Ave.  
Ellsworth Armacost

18. Funeral director Ellsworth Armacost  
 Address 3911 Liberty Heights Ave. Balto. Md.

19. 12-16-46 (Date rec'd by registrar) Registrar [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 19 46 at 4:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11, 19 46, to December 13, 19 46, and that I last saw him alive on December 13, 19 46.

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_  
Erosion of Vessels in Mucosa of  
Small Intestine; Severe Hemorrhage  
xxx in gastro-intestinal tract 10 days

Due to \_\_\_\_\_

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operation Exploratory Laparotomy  
 Date of op. 12-12-46

Autopsy results Substantiated above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

+D Robert M. Cullison  
 23. SIGNATURE R. M. CULLISON, M.D. CLIN. DIR.  
 M. D. or other \_\_\_\_\_

Address VAH FT. HOWARD, MD. Date signed 12-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

Reg. Dist. No. 11793/0

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Woodlawn Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Woodlawn Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6830 Windsor Mill Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No

## 3. (a) FULL NAME

Herman John Fenker3. (b) Social Security Number  
NO

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed6. (b) Name of husband or wife Annie E. Fenker7. Birth date of deceased (mo., day, yr.) September 16, 1876 6. (c) If alive, give age years8. AGE: Years Months Days If less than one day  
70 2 22 hrs. min.9. Birthplace Baltimore Maryland  
(Town, county, and state)10. Usual occupation Whole Sale Ice.11. Industry or business Own BusinessFATHER 12. Name Ludwig Fenker13. Birthplace GermanyMOTHER 14. Maiden name Helena Shluter15. Birthplace Germany16. Informant Harry FenkerAddress 6830 Windsor Mill Road17. Burial Date thereof 12/ 11/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation Baltimore18. Funeral director George W. LittleAddress 2700 Edmondson Ave.112-10 46  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1946 1:08AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec. 1- 1946, to Dec 9 1946  
and that I last saw him alive on Dec 9- 1946

Immediate cause of death

DURATION

Coronary Thrombosis 12/1/46Due to Chc. myocardiitis 1943Due to S. states 1943

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 1663 W. North St.Date signed 12/9/46

RECEIVED  
DEC 10 1945  
BUREAU V B

1-35



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11800361  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Baltimore

City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

503 Virginia Avenue

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 503 Virginia Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war None

### 3.(a) FULL NAME

JOHN HOWARD FLAYHART

### 3.(b) Social Security Number

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Married

B.(b) Name of husband or wife Elva May Flayhart

7. Birth date of deceased (mo., day, yr.) November 12, 1879

8. AGE: Years 67 Months --- Days 20 If less than one day --- hrs. --- min.

9. Birthplace Towson, Balto. Co., Md.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Gas and Electric Co.

12. Name John Edward Flayhart

13. Birthplace Towson, Maryland

14. Maiden name Emma Krout

15. Birthplace Baltimore, Maryland

16. Informant Mrs. Elva M. Flayhart

Address 503 Virginia Ave., Towson, Md.

17. Burial Dec. 4, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Location Towson, Maryland

18. Funeral director John Burns' Sons

Address Towson, Maryland

19. Dec. 3, 1946  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1946 at 5:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 21st 1946, to Dec. 2nd 1946

and that I last saw him alive on Nov 28th 1946

Immediate cause of death Coronary Thrombosis

DURATION 5 minutes

Due to arteriosclerosis

Due to Cyclic Ischemia

Other conditions Cyclic Ischemia

(Include pregnancy within 3 months of death)

Major findings of operations ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE Daniel O. St. Thomas

Address Towson, Md. Date signed 12/3/46

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 1 1947

BUREAU

2-25

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

301

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 16 FUSTING AVE

(c) Hospital or institution:

HOUSE IN THE PINES NURSING HOME

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2745 BAKER ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

## 3 (a) FULL NAME

CAPT. JAMES M. FORD

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife ESTELLE FORD (BEANE)

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.)

MAY 20, 1872

8. AGE:

Years

Months

Days

If less than one day

74

hr.

min.

9. Birthplace

PRINCESS ANNE, MD.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

MARINER

FATHER

12. Name

SAMUEL FORD

13. Birthplace

PRINCESS ANNE, MD.

MOTHER

14. Maiden Name

SARAH SHELTON

15. Birthplace

PRINCESS ANNE, MD.

16 (a) Informant

MELVIN R. FORD

(b) Address

2745 BAKER ST.

17 (a)

BURIAL

(b) Date thereof

DEC 18 '46

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

WOODLAWN

Location

WOODLAWN, MD.

18 (a) Funeral director

JOHN F. DENNY, INC.

(b) Address

715 LIGHT ST.

19 (a)

12-18-46

(b)

DR. H. H. H.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 15, 1946, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1946, to Dec 15, 1946, and that I last saw him alive on Dec 15, 1946.

Immediate cause of death

hypertensive myocardial infarction  
arteriosclerotic type  
disease with hypertrophy & angiosclerosis  
Due to generalized arteriosclerosis

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

W. Michel

Address

2901 Edmondson Ave.

Date signed

M. D. 12/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 632

## CERTIFICATE OF DEATH

11802

Reg. Dist. No. *45*

1. PLACE OF DEATH Baltimore County  
 County Essex  
 City or town Essex  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 Years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Essex  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 826 Eastern Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

3. (a) FULL NAME Mary Forster

3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife George W. Forster  
 8. (c) If alive, give age (D) years  
 7. Birth date of deceased (mo., day, yr.) April 28th, 1870  
 8. AGE: Years 76 Months 8 Days I If less than one day ##### min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
At Home  
 10. Usual occupation  
 11. Industry or business  
 12. Name Unknown Sigrist  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace Unknown

16. Informant Mrs. Anna May Eiler (Daughter)  
 Address 826 Eastern Avenue, Balto: Co. Md.  
 17. Burial Jan. 2, 1947  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
 Cemetery or crematory Holy Redeemer  
 Location Belair Road, Balto: Md.  
 18. Funeral director George J. Ruth, Inc.  
 Address 1735 Harford Avenue

19. 12/31/46  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29th, 1946 19 46 st 14 M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 45 to Dec 28 19 46  
 and that I last saw h. ER alive on Dec. 28 19 46  
 Immediate cause of death Cerebral Hemorrhage  
 Due to Hypertension  
 Due to  
 Other conditions Pneumonia  
 (Include pregnancy within 3 months of death)

## DURATION

6 daysYears

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Thomas B. Hargley M.D.  
 Address 815 Eastern Ave  
Baltimore Md. Date signed 12/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TRANSIT  
PERMIT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

11803

Reg. Dist. No. 501

1. PLACE OF DEATH:  
County Baltimore Co.  
City or town Woodlawn Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md. County  
City or town Baltimore Co.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5614 Windsor Mill Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rogena Foster

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
6. (b) Name of husband or wife John William Foster  
7. Birth date of deceased (mo., day, yr.) Feb 8 - 1868 8. (c) If alive, give age years

8. AGE: Years 78 Months 10 Days 20 If less than one day  
hrs. min.

9. Birthplace Alexandria - Va.  
(Town, county, and state)

10. Usual occupation Home duties

11. Industry or business

12. Name B. R. Isenberger

13. Birthplace Gap - Penna.

14. Maiden name Mary Parker

15. Birthplace Gap - Penna.

16. Informant Mrs. Ruth Quirk

Address 5614 Windsor Mill Rd.

17. Burial Dec. 30, 1946  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Richland

Location McKeesport Pa.

18. Funeral director Manie Cook Syfer

Address 1600 W. North Ave

19. Dec. 30 - 1946 Harry K. Miller  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 19 46 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/18 to 12/28 19 46  
and that I last saw her alive on 12/28 19 46

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerotic Cardiac

Due to vascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Greg S. Blum M. D. or other

Address 1206 E. Preston St. Date signed 12/28/46



UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 441

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Route 40 at Chesapeake Park  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Belts.  
 City or town Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 805 S. Ponca St.  
 (If rural, give LOCATION) ✓

2.(a) If veteran, name war:

## 3. (a) FULL NAME

Paul Frado

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mary (Gross)6. (c) If alive, give age 34 years7. Birth date of deceased (mo., day, yr.) June 7th 1907

8. AGE: Years 39 Months 6 Days 18 If less than one day  
 hrs. min.

9. Birthplace Fairfax, Penna.  
(Town, county, and state)10. Usual occupation Machinist11. Industry or business Beck, Steel12. Name Paul Charles Frado13. Birthplace Italy14. Maiden name Mary Robb15. Birthplace Italy16. Informant Michael C. FradoAddress 422 S. Lehigh St.

17. Burial Date thereof Dec. 28-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. AndrewsLocation Fairfax, Mercer Co. Pa.18. Funeral director John G. ConnollyAddress 418 Eastern Ave. Ext. 2119. Dec. 25 19 46 John G. Connolly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25- 19 46 at 3:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

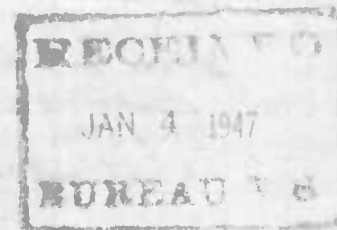
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public PlaceMeans of Injury Struck by Auto Injured at work? No23. SIGNATURE W B Davis M.D.N.Y. med. exam. Saint M. D. or otherAddress Dundalk, Md. Date signed 12/25/46



2-25

2-440-2-10

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1180538

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson 4, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution?

2 yrs 1 mo 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town Darlington  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Katherine Rebecca Gale

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Donald Gale Gale

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 4 1880

8. AGE:

Years

66

Months

9

Days

25

If less than one day

hrs. min.

9. Birthplace

Harford Co. Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John F. Smith

13. Birthplace

Baltimore Md.

MOTHER

14. Maiden name

Margaret Burkins

15. Birthplace

Darlington Md.

## Personal History - Hospital Records

16. Informant

Address Eudowood Sanatorium, Towson 4, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec 31, 1946  
(month) (day) (year)

Cemetery or crematory

Darlington Cem.

Location

Harford Co. Md.

18. Funeral director

H. D. Bailey

Address

Darlington Md.

19.

(Data rec'd by registrar)

19.

W. A. Bridges Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 2919 46, at 7:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1419 46

to

Dec 2919 46and that I last saw h. alive on Dec 28 19 46

Immediate cause of death

Pulmonary Tuberculosis

DURATION

2 1/2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. A. Bridges

M. D. or other

Address Towson 4, Md.

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 7 1947  
BUREAU S.

2-25

2-380-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death cleanly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11806

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore Stoneleigh  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

412 Murdock Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Baltimore Stoneleigh  
(If outside city or town limits, write RURAL and give nearest town)Street No. 412 Murdock Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Adam J. Geyer

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Alma B. Geyer

7. Birth date of deceased (mo., day, yr.)

Nov. 22, 1881

6. (c) If alive, give age years

8. AGE: Years 65 Months 1 Days 3 If less than one day  
hrs. min.9. Birthplace Baltimore Md.  
(Town, county, and state)10. Usual occupation Settlement Officer11. Industry or business The Trust Guaranty Co.12. Name John Geyer13. Birthplace Baltimore, Md.14. Maiden name Friedricha Boerner15. Birthplace Baltimore, Md.16. Informant Alma B. GeyerAddress 412 Murdock Rd.17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec. 28, 1946  
(month) (day) (year)Cemetery or crematory Smith RidgeLocation Pikesville, Md.18. Funeral director Wm. Cook, Inc.Address 1217 St. Paul St.19. 12/27 86 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1946 at 6<sup>00</sup> A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1946 to Dec 25 1946and that I last saw him alive on Dec 24 1946

Immediate cause of death

Coronary ThrombosisDue to Arteriosclerotic heart disease

Due to

Other conditions Diabetes mellitus

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. Carter M. D. or otherAddress 11 C. Chase St. Date signed Dec 25, 1946

## DURATION

4 1/2 years10 years

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 921

## CERTIFICATE OF DEATH

Reg. Dist. No. 3

11803

1. PLACE OF DEATH  
 County Baltimore  
 City or town Pleasant Green  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Pleasant Green  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
Mary Matilda Gell

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife John C. Gell  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Nov 11 - 1863  
 8. AGE: Years 83 Months 9 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace White House, Balt Co. Md.  
 (Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business None

FATHER 12. Name William Holstner

13. Birthplace Piquette, Wm.

MOTHER 14. Maiden name Impf

15. Birthplace Wilmington

16. Informant Mrs. Janie Gell

Address Registerstown, Md.

17. Burial Burial Date thereof Dec 15/46  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Pleasant Green

Location Balt Co.

18. Funeral director Edw. A. Tipton

Address Hampstead Md

19. Dec - 13 - 19 46 Mary B. Eline  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1946 at 8:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5, 1946 to Dec 12, 1946 and that I last saw her alive on Dec 6, 1946

Immediate cause of death Chronic Myocarditis unknown DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Direct conditions Senile Atrophy - Unknown

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Edw. M. Bruck, M.D. M. D. or other

Address Hampstead Md Date signed 12/12/46



RECEIVED

DEC 17 1946

BUREAU 18

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11808

Reg. Diat. No.

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 16 days  
Hospital, institution, or street address where death occurred:  
Vet. Adm. Hosp., Fort Howard, Maryland  
How long in hospital or institution? 16 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2306 Cedley Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war. WW I

### 3. (a) FULL NAME

WILLIAM RIDGE GILLEY

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Dessie Gilley

6. (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 10/31/1892

8. AGE: Years Months Days It less than one day  
54 1 29 hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Unemployed (Hotel Clerk)

11. Industry or business Armistead Hotel

12. Name Tough E. Gilley

13. Birthplace Baltimore Md

14. Maiden name Mary E. Caron

15. Birthplace Baltimore Md.

16. Informant Clinical Records Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/47  
(month) (day) (year)

Cemetery or crematory U. S. National Burial

Location 1219 St. Paul St.

18. Funeral director William Cook, Inc.

Address St. Paul & Preston Sts. Balto. Md.

19. (Date rec'd by registrar) 1-3-47

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 19 46 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14 19 46 to December 30 19 46 and that I last saw him alive on December 30 19 46

Immediate cause of death Hemorrhage from duodenal ulcer DURATION Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. CLIN. DIR. M.D. or other

Address V.A.H. PT. HOWARD, MD. Date signed 12-31-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore <sup>670</sup>

## CERTIFICATE OF DEATH

11809

Reg. Dist. No.

38

### 1. PLACE OF DEATH:

County Baltimore  
City or town Ruston  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 years  
Hospital, institution, or street address where death occurred Dr. Bowditch Training School  
How long in hospital or institution? 4 years

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Baltimore  
City or town Balt.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4802 W. York Rd  
(If rural, give LOCATION)  
2. (a) If veteran, name war none

### 3. (a) FULL NAME

Roger William Glover

### 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) Feb-4-1939 6. (c) If alive, give age years

8. AGE: Years 7 Months 10 Days 15 If less than one day hrs. min.

8. Birthplace Altoona, Pa.  
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER 12. Name Geo. W. Glover Jr.  
13. Birthplace Penna.

MOTHER 14. Maiden name Anna Marie Bittner  
15. Birthplace Penna.

16. Informant Mr. G. W. Glover Jr. (father)  
Address 1 Baltimore Md.

17. Cremation Date thereof Dec-21-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Green Mount  
Location Baltimore Md

18. Funeral director Stewart-Morris Company  
Address 108 W. North Ave.

19. 12/20 48 Dr. H. H. H. H.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 19 46 at 5 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 45 to Dec 19 46 and that I last saw him alive on Dec 19 46

Immediate cause of death Cerebral Degenerative Disease DURATION 4 yrs.  
Malnutrition 1 yr.

Due to Malnutrition

Other conditions Mental Deficiency built

(Include pregnancy within 8 months of death)

Major findings of operations none Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide none Date of none  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury none Injured at work? none

23. SIGNATURE Walter G. G. G. M. D. or other none  
Address 48 E. 33rd St. Date signed 12/20/46

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11810

Reg. Dist. No. 3d1

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville 28  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 yrs. 4 mths. 19 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 13 yrs. 4 mths. 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County ---  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1003 S. Charles Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ---

## 3. (a) FULL NAME

Ray Goodman

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Isidore Goodman

7. Birth date of deceased (mo., day, yr.) June 12, 1885  
 6.(c) If alive, give age 2 years

8. AGE: Years 61 Months 5 Days 25 If less than one day  
 ....hrs. ....min.

9. Birthplace Germany  
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business Home12. Name Daniel Dembar13. Birthplace Germany14. Maiden name Ida ?15. Birthplace Germany16. Informant Hospital records

Address

17. Burial Date thereof Dec 9/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bnai IsraelLocation Southern ave19. Funeral director Sol Lerner BrosAddress 1124 W North ave

19. dec 8 19 46 Harriet Miller  
 (Date rec'd by registrar) (year) (name) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 19 46 at 7:20 am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19Immediate cause of death Cardiac failure DURATIONDue to Cardiovascular diseaseDue to sudden deathOther conditions lunging

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ger M Kieffer Dep. Med.Address 1010 Leide ave Date signed Dec 7 46

RECEIVED

DEC 11 1946

BURMA

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PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

11811

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 years, 11 mo.s., 10 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 11 years, 11 mo.s., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County BC  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 819 N. Madeira St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name was

## 3. (a) FULL NAME

Frances Gozeler (Gosela) (Gorzela)

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife John Gozeler

6. (c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) May 3, 1882

8. AGE: Years Months Days If less than one day  
64 7 21 hrs. min.9. Birthplace Czechoslovakia  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Joseph Schultz

13. Birthplace Czechoslovakia

14. Maiden name Sophia Nehaba

15. Birthplace Czechoslovakia

16. Informant Hospital records

Address Catonsville 28, Md.

17. Burial Date thereof 12-27-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy Redeemer  
Baltimore, Md.

Location

18. Funeral director Frank Cvach &amp; Son

Address 900 N. Chester St.

19. Dec 24 19 44 R. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 24, 1946 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14 19 35 to December 24 19 46

and that I last saw her alive on December 24, 1946

Immediate cause of death Acute exacerbation  
of chronic myocardial failureDURATION  
60 hoursDue to Chronic arteriosclerotic  
C-V disease

Indef.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry C. A. Mead, M. D. M. D. or other

Address Catonsville, 28, Md. Date signed 12/24/46



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 11812 P 320

### 1. PLACE OF DEATH

County Bald

City or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs

Hospital, institution, or street address where death occurred:  
Augsbury Home

How long in hospital or institution? 17 yrs

### 3. (a) FULL NAME

Louisa C. Goeck

### 3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widow

B. (b) Name of husband or wife Herman

7. Birth date of deceased (mo., day, yr.) Dec 26. 1859 6. (c) If alive, give age 87 years

8. AGE: 87 Years Months Days If less than one day hrs. min.

9. Birthplace Philadelphia  
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business Unknown

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Records

Address Augsbury Home

17. Burial, cremation, or removal, Which? Burial Date thereof 1/31/47  
(month) (day) (year)

Cemetery or crematory Northwood Cem

Location Philadelphia Pa

16. Funeral director L. J. Heenan & Son

Address 32 S. Beadway

19. 1-2 47 DR  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford

City or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Campfield Rd.  
(If rural, give LOCATION)

2. (a) If veteran, name war

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31. 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 6th 1946, to Dec. 31 1946, and that I last saw her alive on Dec. 29th 1946.

Immediate cause of death

1) Bacteremia of  
Werners

DURATION

9 mo.

Due to

Due to

Other conditions - Arteriosclerosis  
Heart Disease  
(Include pregnancy within 3 months of death)

5 yrs

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Carl L. Chambers M.D.

Address 4108 Liberty Hts. Date signed 12/31/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

11813

## 1. PLACE OF DEATH:

County Baltimore  
 City or town White Hall  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Baltimore  
 City or town White Hall  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Noah M. Grove

## 3. (b) Social Security Number

717-02-6874

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife \_\_\_\_\_

## 6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

June 16, 1898

## 8. AGE:

48614

hrs. min.

## 9. Birthplace

Parkton, Ind

(Town, county, and state)

## 10. Usual occupation

Crossing Watchman R.R.

## 11. Industry or business \_\_\_\_\_

## FATHER

## 12. Name

John A. Grove

## 13. Birthplace

Unknown

## MOTHER

## 14. Maiden name

Ella C. Miller

## 15. Birthplace

Unknown

## 16. Informant

Hary Grove

## Address

White Hall, Ind

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

Jan 1-1947  
(month) (day) (year)

## Cemetery or crematory

Mt. Zion

## Location

Trueland, Ind

## 18. Funeral director

Howard S. Markline

## Address

White Hall, Ind

## 19.

Jan 1, 1947  
(Date rec'd by registrar)Mrs. Howard S. Markline  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Dec 30, 1946, at 9 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

head on arrival  
 and that I last saw him alive on arrival

## Immediate cause of death

Coronary occlusion

## DURATION

## Due to \_\_\_\_\_

## Due to \_\_\_\_\_

## Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

## Major findings of operations \_\_\_\_\_

#

Date of op. \_\_\_\_\_

## Autopsy results \_\_\_\_\_

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

G. M. France

M. D. or other

## Address

Parkton, Ind

## Date signed

1/1/47

RECEIVED

JAN 4 1947

BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore #7d

## CERTIFICATE OF DEATH

Reg. Dist. No. 410

## 1. PLACE OF DEATH:

County BaltimoreCity or town Bundack-22  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 70

Hospital, institution, or street address where death occurred:

1 Admiral Boulevard

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Bundack  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 Admiral Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Hobart Haines

## 3. (b) Social Security Number

none

## 4. Sex

male

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

married

## 6.(b) Name of husband or wife

Helena Haines

## 7. Birth date of

deceased (mo., day, yr.)

24 October 1876

## 6.(c) If alive, give age

67 years

## 8. AGE:

Years

70

Months

1

Days

15

If less than one day

.....hrs. ....min.

9. Birthplace Washington - Baltimore - Maryland  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

Insurance Business - Self

## FATHER

## 12. Name

Levi Haines

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Emma Ensor

## 15. Birthplace

Maryland

## 16. Informant

Helena Haines

## Address

1 Admiral Blvd. Bundack-22

## 17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Moreland Mem. Pk.

## Location

Balto. Co. Maryland

## 18. Funeral director

WM. J. TICKNER & SONS

## Address

Balto., Md.

## 19.

(Date rec'd by registrar)

12-11-46X6McHedding

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8 December 1946 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

14 July 1946 to 9 December 1946and that I last saw him alive on 9 December 1946

## Immediate cause of death

Carcinoma of lung

## DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bernard W. Jellod M.D.

M. D. or other

Address

8 Liberty ParkwayDate signed 9 Dec. 1946Bundack-22 Dist.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

11815

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Owings Mills (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Baltimore  
 City or town Owings Mills (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Green Spring Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war The

## 3. (a) FULL NAME

William J. Harris

## 3. (b) Social Security Number

None

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Anna Elizabeth (ne Meyer)

7. Birth date of deceased (mo., day, yr.)

Jan. 2, 1854

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

92112

hrs.

min.

9. Birthplace

Owings Mills, Md.  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Ephraim Harris

13. Birthplace

Maryland

MOTHER

14. Maiden name

Mary Uhler

15. Birthplace

Maryland

16. Informant

Mrs. Mary Robinson

Address

Owings Mills, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 7 1946  
(month) (day) (year)

Cemetery or crematory

Gravely Ridge

Location

Pitersville, Md.

18. Funeral director

London M. Brooks

Address

Sparks, Md.

19.

Dec. 7 46  
(Date rec'd by registrar)

19.

46Wilmer C. Ensor

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1946 at 10:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19. \_\_\_\_\_ 10. 12-7 19. 46  
 and that I last saw him alive on 12/3/46 19. \_\_\_\_\_

Immediate cause of death

Coronary Thrombosis

DURATION

✓

Due to

myocarditis

Due to

chronic decompensating

Other conditions

✓

(Include pregnancy within 3 months of death)

Major findings of operations

✓Date of op. ✓

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓Date of ✓

Where did injury occur?

✓  
(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James L. Saffell

M. D. or other

Address

Petersville, Md.

Date signed

12/4/46

RECEIVED

DEC 10 1946

BUREAU V A

1-25



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 11810

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

## 3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or

m.

w.

divorced.

married

6 (b) Name of husband or wife

Stephanie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

57

4

21

hr.

min.

9. Birthplace

Pa.

(Town, county, and state)

10. Usual Occupation

Tool Maker

11. Industry or business

Brown Park + Seal Co.

FATHER

12. Name

August C. Heckel

MOTHER

13. Birthplace

Germany

14. Maiden Name

Maria Sporing

15. Birthplace

Germany

16 (a) Informant

Mrs. Stephanie Heckel

(b) Address

5800 Gwynn Oak Ave

17 (a) Burial

(b) Date thereof 12/11/46

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

3801 Frederick Ave

18 (a) Funeral director

Harry H. Winkle

(b) Address

4101 Edmonson Ave

19 (a)

(Date rec'd by registrar)

(b)

Registrar

## 2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5800 Gwynn Oak Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1946, at 3:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1946 to Dec 8 1946

and that I last saw him alive on Dec. 7 1946

Immediate cause of death

CORONARY Thrombosis

Duration

5 min.

Due to Arteriosclerotic heart disease.

2 Mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

## PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Percy H. Sutley

M. D.

Address

3417 Gwynn Falls

Date signed Dec 9, 46

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
cemetery and burial date MARYLAND STATE DEPARTMENT OF HEALTH  
- telephone call from undertaker 2411 N. Charles St., Baltimore  
12/12/46 dm

# CERTIFICATE OF DEATH

Reg. Dist. No. *Be*

## 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 47 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
How long in hospital or institution? 47 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. General Delivery  
(If rural, give LOCATION)  
2. (a) If veteran, name war WW-I

## 3. (a) FULL NAME

JOHN N. HENDRICKS

## 3. (b) Social Security Number

487-18-4069

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 5-7-92 6. (c) If alive, give age years

8. AGE: Years 54 Months 7 Days 0 If less than one day hrs. min.

9. Birthplace Washington, D. C.  
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name John Hendricks

13. Birthplace Pennsylvania

14. Maiden name Elizabeth ?

15. Birthplace Ohio

16. Informant Registrar's Office, Clin. Records  
Address Vets. Adm. Hospital, Ft. Howard, Md.

17. Burial Date thereof Dec 11-46  
(Burial, cremation, or removal of body) U.S. Baltimore National  
Cemetery or crematory Baltimore Md.  
Location Elsworth Armory

18. Funeral director 3911 Liberty Heights Ave  
Address 12-9 46

19. (Date rec'd by registrar) 12-9 46 Registrar [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1946 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21, 1946 to December 7, 1946

and that I last saw him alive on December 7, 1946

Immediate cause of death TUBERCULOUS PNEUMONIA DURATION 2 months

Due to Tuberculosis, Chronic Pulmonary 7 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Robert Lamer MD M. D. or other

Address V. A. Ft. Howard, Md. Date signed 12/7/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B-2*

## CERTIFICATE OF DEATH

11818

Reg. Dist. No. *350*

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 27 days  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution? 27 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Harford  
City or town Pylesville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route #1  
(If rural, give LOCATION)  
2.(a) If veteran, name war WW I

### 3.(a) FULL NAME

WILLIAM H. HOLLINGSHEAD

### 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Effie Hollingshead

7. Birth date of deceased (mo., day, yr.) March 5, 1894 6.(c) If alive, give age 51 years

8. AGE: Years 52 Months 9 Days 20 If less than one day  
.....hrs. ....min.

9. Birthplace White Hall, Maryland  
(Town, county, and state)

10. Usual occupation Unemployed

### 11. Industry or business

12. Name Strong Hollingshead

13. Birthplace Maryland

14. Maiden name Maggie Bisker

15. Birthplace Pennsylvania

16. Informant Clinical Records Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof Dec. 25-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory White Liberty

Location White Hall, Md

18. Funeral director Howard S. Markel

Address White Hall, Md

19. Dec. 27 19 46 Mrs. Howard S. Markel  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 19 46 at 8:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 28 19 46, to December 25 19 46, and that I last saw him alive on December 25 19 46.

Immediate cause of death Congestive Heart Failure DURATION Nov. 28, 1946

Due to Pleural Effusion, right 34 Days

Due to Pneumonia, rt. lower lobe 34 Days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town), (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. CLIN. DIR.

Address V.A. Ft. Howard, Md. Date signed 12-26-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1946

RECEIVED

71-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

## CERTIFICATE OF DEATH

11873

Reg. Dist. No. *IX*

## 1. PLACE OF DEATH:

County *Baltimore Co*City or town *Essex*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*315 Montrose an*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State *Md.* County *Balto.*City or town *Essex*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *315* *Montrose an*  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*Mary E. Shul*

## 3. (b) Social Security Number

4. Sex

*Female*

5. Color or race

*White*

6.(a) Single, married, widowed, or divorced

*Married*

6.(b) Name of husband or wife

*George A.*

7. Birth date of deceased (mo., day, yr.)

*Dec. 1, 1888*

8.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

*58*

hrs. min.

9. Birthplace

*Balto. Md.*  
(Town, county, and state)

10. Usual occupation

*Housewife*

11. Industry or business

FATHER

12. Name

*John J. Shulby*

13. Birthplace

*Balto. Md.*

MOTHER

14. Maiden name

*Margaret*

15. Birthplace

*Ireland*

16. Informant

*George A. Shul*

Address

*3307 C. Donnell Rd.*

17.

(Burial, cremation, or removal. Which?)

Date thereof

*Dec 31-46*  
(month) (day) (year)

Cemetery or crematorium

*Coke Lawn*

Location

*Eastern Ave. Rd.*

18. Funeral director

*John E. Nathan*

Address

*300 E. Balto. Md*

19.

(Date rec'd by registrar)

*12-31-46*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 28-* 19 *46*, at *1-55 A. M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Oct 1* 19 *46*, to *Dec 28* 19 *46*and that I last saw her alive on *Dec 28* 19 *46*

Immediate cause of death

*Toxemia*

DURATION

Due to

*Carcinoma of Rectum**1 yr*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Geo. W. Baumgardner M.D*  
M. D. or other

Address

*Balto 6*Date signed *12-28-46*



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11820

Reg. Dist. No. 301

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 9 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 9 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3625 Chestnut Avenue - (11)  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

Anna Johnson

### 3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Charles Johnson  
Deceased 6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) ? April, 1879  
8. AGE: Years 67 Months 8 Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Austria  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business Home  
12. Name (Unknown) Schaefer  
13. Birthplace Austria  
14. Maiden name Unknown  
15. Birthplace Austria

16. Informant Hospital records  
Address Catonsville, 28, Md.  
17. 12-18-46 Lorraine  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory \_\_\_\_\_  
Location Baltimore  
18. Funeral director Joe J. Herr & Son  
Address 3601 Kentucky Ave  
12/17/46  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH December 15, 1946 at 7:20 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6, 1946 to December 15, 1946  
and that I last saw him ex alive on December 15, 1946

Immediate cause of death Acute myocardial failure DURATION minutes  
Due to Chronic myocardial insufficiency with dilatation Indefinite  
Due to \_\_\_\_\_  
Other conditions Movable tumor right neck type undetermined 15 years  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results None  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE Isadore Fuchs, M.D.  
Address Catonsville, 28, Md. Date signed 12/15/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



380  
33.75  
65

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

11821

## CERTIFICATE OF DEATH

Reg. Dist. No. 372

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Masonic Home, Cockeysville Md  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 2117 N. Charles St.  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Arthur Johnson

## 3. (b) Social Security Number

246-05-6129

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Mary E.6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) 1872 July 25

8. AGE: Years 74 Months 4 Days 9 It less than one day  
 hrs. min.

9. Birthplace Yorkshire England  
(Town, county, and state)10. Usual occupation Bld. Construction Supt.

11. Industry or business

12. Name Wm. Johnson13. Birthplace Yorkshire England14. Maiden name Agnes Piesch15. Birthplace Herford England16. Informant Wm. McSpencerAddress Masonic Home17. Burial Date thereof Dec 7-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory United Brethern, Thurmont MdLocation Thurmont Md18. Funeral director Wm. CookAddress St. Paul & Preston St19. Dec 5 19 46 L. M. Schwab  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Dec 1946 at 9:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1946 to Dec 1946and that I last saw him alive on 4 Dec 1946Immediate cause of death Coronary ThrombosisDue to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kusch D.

M. D. or other

Address Cockeysville, Md. Date signed 4 Dec 1946

RECEIVED  
DEC 6 1946  
BUREAU V S

1-25

2-370-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

## CERTIFICATE OF DEATH

11822

Reg. Dist. No. 301

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 days  
 Hospital, institution, or street address where death occurred:  
315 Inglewood Ave.  
 How long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard  
 City or town Ellicott City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Main St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

George M Johnson

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single; married, widowed, or divorced Widower

8. (b) Name of husband or wife Clara Johnson

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1965

8. AGE: Years 81 Months 2 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ellicott City, Md.  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Anthony M Johnson13. Birthplace Pa.14. Maiden name Josephine Harney15. Birthplace Md.16. Informant Mrs Wm WarfieldAddress Highland, Md.17. Burial Date thereof 12-9-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. JohnsLocation Ellicott City, Md.18. Funeral director J.C. HigginbothamAddress Ellicott City, Md.19. 12-8- 1946 Harry Miller  
(Date rec'd by registrar) (month) (day) (year) Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1946, at 2:30 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-15 1946 to 12-7 1946and that I last saw him 12-7 1946 alive on 12-7 1946

Immediate cause of death Arteriosclerotic Cardiovascular Disease  
 DURATION 2 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George E. Bungtorf M.D.Address Ellicott City, Md. Date signed 12-8-46

1141

NOTICE TO THE PUBLIC

SEE CONTENT

RECEIVED  
DEC 11 1946  
BUREAU 78

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11823

Reg. Dist. No.

370

## 1. PLACE OF DEATH:

County Balts.City or town White Hall, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balts.City or town White Hall  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Georgianne E. Johnson

## 3. (b) Social Security Number

none

4. Sex

F.

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Nicholas Johnson

T. Birth date of

deceased (mo., day, yr.)

June 29, 1957

8. AGE:

Years

Months

Days

If less than one day

87511

hrs.

min.

9. Birthplace

Monkton, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name George Hace13. Birthplace Monkton, Md.14. Maiden name Mary Jane Burke15. Birthplace White Hall, Md.16. Informant Raymond JohnsonAddress White Hall, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12/12/46

(month) (day) (year)

Cemetery or crematory Union ChapelLocation White Hall, Md.18. Funeral director William ChatmanAddress 1701 M.E. Culloh St. Balts. Md.19. 12/11

(Date rec'd by registrar)

19. 46J.W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 19 46, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/7 to Dec. 9 19 46and that I last saw him alive on Dec. 8 19 46

Immediate cause of death

Cerebral Thrombosis

DURATION

Due to

Due to

Other conditions

Hypertension,  
Arterio-sclerotic

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. W. France  
Parleton, Md. Date signed 12/9/46

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12595

301

## 1. PLACE OF DEATH:

County.....**Baltimore**  
 City or town.....**Catonsville**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **13 years, 7 mos., 20 days**  
 Hospital, institution, or street address where death occurred:  
**Spring Grove State Hospital**  
 How long in hospital or institution? **13 years, 7 mos., 20 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State.....**Maryland** County.....  
 City or town.....**Baltimore**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....**102 South Albemarle Street**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**Mikita Kandraczuk**

## 3. (b) Social Security Number

4. Sex.....**male**  
 5. Color or race.....**white**  
 6.(a) Single, married, widowed, or divorced.....**married**

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....**December 1, 1880**

8. AGE: Years.....**66** Months.....**-** Days.....**27**  
 If less than one day..... hrs. .... min.

9. Birthplace.....**Russia**  
 (Town, county, and state)

10. Usual occupation.....**Laborer**11. Industry or business.....**?**12. Name.....**Idam Kandraczuk**13. Birthplace.....**?**14. Maiden name.....**Maria ?**15. Birthplace.....**?**16. Informant.....**Hospital records**Address.....**Catonsville-28, Maryland**17. Buried.....**2-25-47**

(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory.....**Spring Grove State Hospital**Location.....**Catonsville 28, Md.**18. Funeral director.....**Spring Grove State Hospital**Address.....**Catonsville 28, Md.**19. **2-25**.....**47**.....**Harry J. Miller**

(Date rec'd by registrar)..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....**December 28**.....**46**.....**8:45 a.m.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**May 8**.....**33**.....**December 28**.....**46**and that I last saw him alive on.....**December 28**.....**46**

Immediate cause of death.....

**Acute dilatation of heart**.....DURATION.....**few hours**Due to.....**Cardiovascular-renal disease**.....**indefinite**

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....**as above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....**Isadore Tuerk****Isadore Tuerk, M.D.**..... M. D. or otherAddress.....**Catonsville-28, Md.**..... Date signed.....**2-24-47**

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ 11824 381  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
607 Bosley Avenue  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 607 Bosley Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

### 3. (a) FULL NAME

HARRIET LORETTA BOWEN KEAGY

### 3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-------------------------	----------------------------------	----------------------------------------------------------------

6. (b) Name of husband or wife Henry C. Keagy

7. Birth date of deceased (mo., day, yr.) March 6, 1863  
6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:	Years	Months	Days	If less than one day
<u>83</u>	<u>8</u>	<u>15</u>	_____ hrs.	_____ min.

9. Birthplace Towson, Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Henry L. Bowen

13. Birthplace Towson, Maryland

14. Maiden name MaryvAnne Parks

15. Birthplace Texas, Maryland

16. Informant Henry C. Keagy

Address 607 Bosley Ave., Towson, Md.

17. Burial Date thereof Dec. 23, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Location Towson, Maryland

18. Funeral director John Curran's Sons

Address Towson, Maryland

19. Dec. 23, 1946  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1946, at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7<sup>th</sup> 1946, to Dec 21<sup>st</sup> 1946  
and that I last saw him alive on December 20<sup>th</sup> 1946

Immediate cause of death \_\_\_\_\_

Hypertrophic Cirrhosis of Liver

DURATION  
25 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

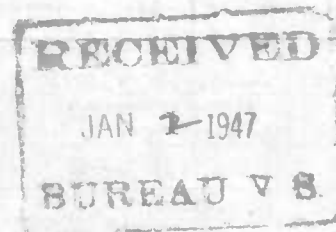
23. SIGNATURE Dr. J. H. Hoo  
M. D. or other \_\_\_\_\_

Address Towson 4, Md Date signed Dec 27, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 11825 320

## 1. PLACE OF DEATH:

County Balto.City or town Pikeville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 95 yrs.Hospital, institution, or street address where death occurred: —How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto.City or town Pikeville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 213 Church Lane  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

William J. Kennedy

## 3. (b) Social Security Number

—

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

—

## 7. Birth date of

deceased (mo., day, yr.)

Sept 28 - 18686. (c) If alive, give age — years

## 8. AGE:

Years

Months

Days

If less than one day

78224

hrs.

min.

## 9. Birthplace

Baltimore Co. Md  
(Town, county, and state)

## 10. Usual occupation

Florist

## 11. Industry or business

FATHER

## 12. Name

James J. Kennedy

## 13. Birthplace

Ireland

MOTHER

## 14. Maiden name

Eliza Canoy

## 15. Birthplace

Ireland

## 16. Informant

Joseph Kennedy

## Address

213 Church Lane, Pikeville Md

## 17. Burial

(Burial, cremation, or removal, Which?)

## Date thereof

12/24/46  
(month) (day) (year)

## Cemetery or crematory

H. Charles

## Location

Pikeville Md.

## 18. Funeral director

Frank H. Newell

## Address

Pikeville Md.

## 19. M-23-

(Date rec'd by registrar)

19. 46

Dr. E. E. Nicholas

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

12/2319. 46 at 11:10 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

several years 19. — to 12-23-1946and that I last saw him alive on 12-22- 19. 46

## Immediate cause of death

Chronic myocarditis

## DURATION

## Due to

arterio sclerosis

## Due to

## Other conditions

Senility

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op. —

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of —

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) —

## Means of injury

Injured at work? —

## 23. SIGNATURE

E. E. Nicholas MD

M. D. or other

Address Pikeville Md Date signed 12-23-46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

RECEIVED  
DEC 26 1946  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

11826

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH:</b> County <u>Baltimore</u> City or town <u>Catgate</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>MD</u> County <u>Baltimore</u> City or town <u>Catgate</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>4504 Lakeshore Rd</u> (If rural, give LOCATION) 2. (a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Alexander Gordon Kidd</u>				<b>3. (b) Social Security Number</b> <u>212-01-5939</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>Mildred Rose</u>				<b>6. (c) If alive, give age</b> <u>45</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>June 17</u>				<b>8. AGE:</b> Years <u>61</u> Months _____ Days _____ If less than one day _____ hrs. _____ min.			
<b>9. Birthplace</b> <u>New Jersey</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Salesman</u>			
<b>11. Industry or business</b>				<b>12. Name</b> <u>—</u>			
<b>13. Birthplace</b> <u>—</u>				<b>14. Maiden name</b> <u>—</u>			
<b>15. Birthplace</b> <u>—</u>				<b>16. Informant</b> <u>Melvin E Rogers</u> Address <u>608 Lennox St</u> <u>Cremation</u> Date thereof <u>12/16/46</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Green Mount</u> Location <u>Baltimore, Md</u> <u>William J. Johnson</u>			
<b>17. Funeral director</b> <u>William J. Johnson</u> Address <u>1217 St Paul St</u>				<b>18. Funeral director</b> <u>—</u> Address <u>—</u>			
<b>19. Dec 14 1946</b> (Date rec'd by registrar)				<b>20. DATE OF DEATH</b> <u>Dec 13 1946</u> at <u>10</u> <sup>50</sup> <u>9</u> M			
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Dec 10 1946</u> to <u>Dec 13 1946</u> and that I last saw him alive on <u>Dec 13 1946</u>				<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____			
<b>23. SIGNATURE</b> <u>M. A. Jacobs</u> <u>617 North St Rd</u>				<b>24. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>25. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>26. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>27. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>28. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>29. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>30. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>31. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>32. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>33. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>34. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>35. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>36. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>37. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>38. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>39. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>40. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>41. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>42. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>43. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>44. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>45. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>46. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>47. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>48. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>49. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>50. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>51. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>52. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>53. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>54. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>55. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>56. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>57. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>58. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>59. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>60. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>61. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>62. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>63. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>64. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>65. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>66. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>67. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>68. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>69. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>70. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>71. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>72. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>73. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>74. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>75. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>76. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>77. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>78. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>79. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>80. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>81. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>82. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>83. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>84. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>85. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>86. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>87. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>88. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>89. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>90. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>91. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>92. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>93. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>94. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>95. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>96. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>97. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>98. SIGNATURE</b> <u>—</u> Address <u>—</u>			
<b>99. SIGNATURE</b> <u>—</u> Address <u>—</u>				<b>100. SIGNATURE</b> <u>—</u> Address <u>—</u>			

23. SIGNATURE M. A. Jacobs  
617 North St Rd  
 Address — Date signed 12/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

11827

Reg. Dist. No. 370

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Sparks (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years  
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... md County... Baltimore  
 City or town... Sparks (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Shuman Hill Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Cor James Klingfelter

## 3. (b) Social Security Number

none

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Luther W.C. Klingfelter  
 6. (c) If alive, give age 69 years  
 7. Birth date of deceased (mo., day, yr.) Feb. 25, 1885  
 8. AGE: Years 61 Months 9 Days 20 It less than one day  
 hrs. min.

9. Birthplace Harford Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home  
 12. Name James Alexander  
 13. Birthplace Harford Co., Md.  
 14. Maiden name Unknown  
 15. Birthplace "

16. Informant L. W. C. Klingfelter  
 Address Sparks, Md.  
 17. Burial Date thereof Dec. 18, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Black Rock  
 Location Butler Bk. Co., Md.  
 18. Funeral director Samuel M. Brooks  
 Address Sparks, Md.  
 19. Dec. 16 19 46  
 (Date rec'd by registrar) Registrar Wilmer C. Eason

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 19 46 at 11:30 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-8 19 43 to 12-15 19 46  
 and that I last saw him alive on 12-5 19 46

Immediate cause of death

Coronary Thrombosis

DURATION

InstantDue to Varicose Veins etc.10 yrs.

Due to

Other conditions Varicose Veins10 yrs.

(Include pregnancy within 3 months of death)

Major findings at operations

Frank

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

D. D. CaplesM. D.

M. D. or other

Address

Reisterstown, Md.Date signed 12-16-46

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH

STATE DEPARTMENT OF HEALTH

MEDICAL CERTIFICATE

RECEIVED  
DEC 19 1945  
BUREAU V.B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

11828

Reg. Dist. No. 381

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson 4, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one yr + 2 mos

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4711 Grindon Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Harry Boggs Kramer.

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M6. (b) Name of husband or wife Virginia Kramer6. (c) If alive, give age 46 years7. Birth date of deceased (mo., day, yr.) May 6 18878. AGE: Years 59 Months 7 Days 12 If less than one day hrs. min.9. Birthplace Baltimore City, Md  
(Town, county, and state)10. Usual occupation Conductor, St. Ry.11. Industry or business Street Railway12. Name George Kramer13. Birthplace Baltimore, Md14. Maiden name Josephine Cox15. Birthplace Baltimore

## Personal History - Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md17. BURIAL Date thereof Dec 20 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CHESTER CEM.Location CHESTERTOWN, KENTCO, Md.18. Funeral director Willis WellsAddress Chestertown, Md.19. 12/18/46 19 46 Registrar W. C. ...  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 46 at 330 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 19 45, to Dec 18 19 46 and that I last saw him alive on Dec 18 19 46Immediate cause of death Pulmonary Tuberculosis DURATION Feb 1945Arthritis, Rt Knee June 1945  
Culson

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

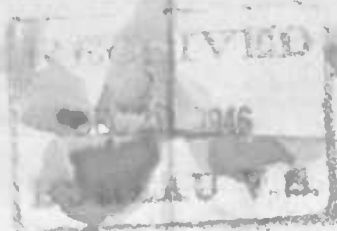
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W A Bridges M. D. or otherAddress Towson 4, Maryland Date signed 12/18/46



1-25

2-380- 1-10



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

## CERTIFICATE OF DEATH

11829

Reg. Dist. No. 440

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Sparrows Point - 19  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
619 I Street  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Balt  
 City or town..... Sparrows Pt  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 619 I St  
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (a) FULL NAME

William H. Lacey

## 3. (b) Social Security Number

4. Sex..... Male  
 5. Color or race..... Colored  
 6. (a) Single, married, widowed, or divorced..... Married

## B. (b) Name of husband or wife.....

Mary

7. Birth date of deceased (mo., day, yr.)  
Mar. 4. 1878

6. (c) If alive, give age..... years

8. AGE: Years..... 68 Months..... 9 Days.....  
 If less than one day..... hrs. .... min.

9. Birthplace..... Fair Hill, Va.  
 (Town, county, and state)

10. Usual occupation..... Steel worker11. Industry or business..... Steel mill12. Name..... Ruben Lacey13. Birthplace..... Va.14. Maiden name..... Harriett Burl15. Birthplace..... Va.16. Informant..... Edward LaceyAddress..... 619 I St Sparrows Pt

17. Burial Date thereof..... 12-7-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. CalvaryLocation..... A. A. Co. Md18. Funeral director..... Sam W. ChaseAddress..... 638 N. Biltmore St. - Balt.

19. Dec 4 19 46  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 3. 46 at..... 6:30 P

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
Mar. 27. 46 to Dec. 3. 46  
 and that I last saw him alive on Dec. 3. 46

Immediate cause of death.....

Cerebral Embolism

DURATION

Sudden

Due to.....

Myocardial degeneration2 yrs.

Due to.....

Atherosclerosis5 yrs.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

Louis N. Tollin

M. D. or other

Address..... 6908 North Point Rd  
Balto - 19 - Md Date signed..... 12/3/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the addition of  
date of death is shown on  
G 109 3/31/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

## CERTIFICATE OF DEATH

Reg. Dist. No. 441

### 1. PLACE OF DEATH:

County Balto.

City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1600 Gale Rd.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balto.

City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1600 Gale Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Isabelle nee Morris

7. Birth date of deceased (mo., day, yr.)

Sept. 22 - 1859

8.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

87

hrs. min.

9. Birthplace

Waterbury, Conn.  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Patrick Lawlor

13. Birthplace

Ireland

14. Maiden name

Julia Hickey

15. Birthplace

Ireland

16. Informant

Mrs. Isabelle Lawlor

Address

1600 Gale Rd.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof 12/12/46  
(month) (day) (year)

Cemetery or crematory

Moreland Memorial

Location

Taylor Ave.

18. Funeral director

John J. Cronelly

Address

418 Eastern Ave. Essex 21 md

19.

(Date rec'd by registrar)

19

47

John J. Cronelly

Registrar

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 22 1946 to Dec 8, 1946

and that I last saw him alive on Dec 8 1946

Immediate cause of death

Hypostatic pneumonia  
Cardiac failure  
Chronic myocarditis  
due to  
age

DURATION

Years

Due to

Other conditions Viral infection cold

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maxwell H. Mund

M. D. or other

Address

417 1/2 Eastern Ave

Date signed 12-11-46

RECEIVED  
MAR 18 1947  
BUREAU VS

1-25

COPY SENT TO County REGISTRAR No. \_\_\_\_\_ DATE 3/18/47

2-440-1-10



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-6

## CERTIFICATE OF DEATH

11831

P

Reg. Dist. No. 310

<b>1. PLACE OF DEATH:</b> County <u>Balto.</u> City or town <u>Villa Nova</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred <u>Prince George Rd</u> How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Md</u> County <u>Balto.</u> City or town <u>Villa Nova</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Prince George Rd.</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>John F. Lehr Jr</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>		<b>MEDICAL CERTIFICATION</b>	
<b>6. (b) Name of husband or wife</b> <u>Alice H. Lehr</u>		<b>6. (c) If alive, give age</b> ..... years		<b>2D. DATE OF DEATH</b> <u>Dec 30<sup>th</sup></u> 19 <u>46</u> at <u>3a</u> P.M.		<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Out</u> 19 <u>46</u> to <u>Dec 30</u> 19 <u>46</u> and that I last saw him alive on <u>Dec 29</u> 19 <u>46</u>	
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>June 10<sup>th</sup> 1889</u>		<b>8. AGE:</b>		<b>Immediate cause of death</b> <u>Coronary Artery Disease</u>		<b>DURATION</b>	
Years <u>57</u>		Months <u>6</u>		Days <u>20</u>		If less than one day ..... hrs. .... min.	
<b>9. Birthplace</b> <u>Balto Md.</u> (Town, county, and state)		<b>10. Usual occupation</b> <u>Plumber</u>		<b>Due to</b>			
<b>11. Industry or business</b> <u>Own Business</u>		<b>12. Name</b> <u>John F. Lehr Sr.</u>		<b>Due to</b>			
<b>13. Birthplace</b> <u>Balto. Md.</u>		<b>14. Maiden name</b> <u>Mary M. Heim</u>		<b>Other conditions</b> <u>Chronic Endocarditis</u> ..... 6 weeks <u>Myocarditis, subacute</u> ..... 6 weeks, approx. (Include pregnancy within 3 months of death)			
<b>15. Birthplace</b> <u>Germany</u>		<b>16. Informant</b> <u>Alice H. Lehr</u>		<b>Major findings of operations</b>		<b>Date of op.</b>	
<b>Address</b> <u>Prince George Rd. - Villa Nova</u>		<b>17. Burial</b> (Burial, cremation, or removal, Which?) <u>Burial</u> Date thereof <u>11/14/47</u> (month) (day) (year)					
<b>Cemetery or crematory</b> <u>Parkwood</u>		<b>Location</b> <u>Parkville Md.</u>		<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>18. Funeral director</b> <u>William Cook Inc.</u>		<b>Address</b> <u>1217 St. Paul St.</u>		<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>			
<b>19. (Date rec'd by registrar)</b> <u>1-27-31</u> 19 <u>46</u>		<b>Registrar</b> <u>Curran</u>		<b>Accident, suicide, or homicide</b> ..... Date of .....			
				<b>Where did injury occur?</b> ..... (City or town) ..... (County) ..... (State)			
				<b>Injured at home, farm, industry, public place (where?)</b> .....			
				<b>Means of injury</b> ..... <b>Injured at work?</b> .....			
				<b>23. SIGNATURE</b> <u>Thos M Abbott</u>		<b>M.D. or other</b>	
				<b>Address</b> <u>4509 Liberty Street</u>		<b>Date signed</b> <u>12-30-46</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

## CERTIFICATE OF DEATH

1183238  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson 4, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since Jan 1, 1946  
 Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Md.  
 How long in hospital or institution? Since Jan 14, 1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Dundalk, Balto 22  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 8218 Dundalk Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Harry Reynolds Lewis

## 3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Elizabeth Lewis7. Birth date of deceased (mo., day, yr.) February 24, 1886 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 60 Months 9 Days 14 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Balto, Md.  
(Town, county, and state)10. Usual occupation Cal. Business11. Industry or business Own12. Name James Lewis13. Birthplace Balto, Md.14. Maiden name E. R. Neal15. Birthplace Balto, Md.

## Personal History - Hospital Records

16. Informant William Cook, Inc.  
Address Eudowood Sanatorium, Towson 4, Md.17. Burial Date thereof 12/12/46  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Balto, Md.Location " Md.18. Funeral director William Cook, Inc.  
Address 1217 St. Paul St.19. 12-10-46 D. H. Bridges  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1946 at 5 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14, 1946 to December 8, 1946 and that I last saw him alive on December 8, 1946

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. H. Bridges M. D. or otherAddress Towson 4, Maryland Date signed 12-8-46



122-a

## Reg. Dist. No. .... 201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

## CERTIFICATE OF DEATH

Reg. Dist. No. 321

### 1. PLACE OF DEATH:

County Baltimore  
City or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 yr., 9 mos., 6 days  
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium  
How long in hospital or institution? 1 yr., 9 mos., 6 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 24 N. Ellwood Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war.

### 3. (a) FULL NAME

Mr. Albert Linkowski

### 3. (b) Social Security Number

# Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Nadya Linkowski  
6. (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) August 7, 1915

8. AGE: Year 31 Months 4 Days 9 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation None

### 11. Industry or business

FATHER 12. Name John Linkowski  
13. Birthplace Russia

MOTHER 14. Maiden name Tillie Semma  
15. Birthplace Russia

16. Informant Mr. Albert Linkowski  
Address 24 N. Ellwood Ave., Balto., Md.

17. Burial Burial Date thereof Dec. 19, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Andrews' Russian Orthodox  
Location Anne Arundel Co., Maryland

18. Funeral director John A. Grebliauckas  
Address 423 S. Paca St., Balto., Md.

19. Dec. 16, 1946  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1946 at 12:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1945 to Dec. 16, 1946 and that I last saw him alive on December 16, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 8 yrs.

Due to Tubercle Bacilli

Due to

Other condition None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D.  
Stewart S. Shaffer, M.D.  
M. D. or other

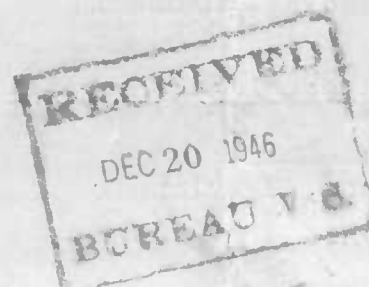
Address Mount Wilson, Md. Date signed 12/16/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

rec'd - 12-18-46



1-25

2-320-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

## CERTIFICATE OF DEATH

Reg. Dist. No. 410

## 1. PLACE OF DEATH:

County BaltimoreCity or town Turner Station  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

602 Main St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 602 Main St. Turner Station  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Jeanette Lipscomb

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

Col.

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Fred. Lipscomb

## 7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age ..... years

1906

## 8. AGE:

Years

40 yrs

Months

July

Days

21

If less than one day

hrs. m/n.

## 9. Birthplace

Virginia  
(Town, county and state)

## 10. Usual occupation

Beautician

## 11. Industry or business

Charles Lee Well

## 12. Name

Virginia

## 13. Birthplace

Minnie Cook

## 14. Maiden name

Virginia

## 15. Birthplace

Leola Lee Well

## 16. Informant

602 Main St. Turner Station

## 17. Burial

(Burial, cremation, or removal. Which?)

Burial Date thereof 12/11/46  
(month) (day) (year)

## Cemetery or crematory

Arlington Mem. Cem.

## Location

Halethorne Balto. Md.

## 18. Funeral director

Metropolitan Funeral Home Inc.

## Address

927 N. Mount St.

## 19. Date rec'd by registrar

12/19 x6 J. W. Kestner  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 19 46, at 6 45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 7, 19 46 to December 8, 19 46and that I last saw her December 8, 19 46Immediate cause of death Bronchial Pneumonia

## DURATION

36 hours

Due to

Followed Acute Bronchitis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William J. Hale, M.D.  
140 Oak Ave

M. D. or other

Date signed 12-8-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17a

## CERTIFICATE OF DEATH

11833 80  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County 7721 Bagley Ave

City or town Parkville, Md.  
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford

City or town Parkville  
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 7721 Bagley Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

### 3. (a) FULL NAME

Louis Lotterer - Sr.

### 3. (b) Social Security Number

4. Sex

m.

5. Color or race

w

6. (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife Annie E.A.

7. Birth date of deceased (mo., day, yr.)

July 27-1875

8. AGE:

Years

Months

Days

If less than one day

71

4

5

hrs.

min.

9. Birthplace

Baltimore, Md.  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

MOTHER

12. Name

Casper Lotterer

13. Birthplace

Germany

14. Maiden name

15. Birthplace

16. Informant

Mrs. Annie Lotterer

Address

7721 Bagley Avenue

17. Burial

(Burial, cremation, or removal, which?)

Date hereof

12-6-46  
(month) (day) (year)

Cemetery or crematory

Parkwood

Location

Baltimore

18. Funeral director

Leonard J. Rusk

Address

5305 Harford Rd.

19.

(Date rec'd by registrar)

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

12/3/46

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

2 Dec

46

at 9:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1940 19 11-24 19 46

and that I last saw him alive on 11-28 19 46

Immediate cause of death

Coronary atherosclerosis

DURATION

18 hrs

Due to

Coronary Atherosclerosis

9 yrs

Due to

Chronic Renal Disease

undetermined

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Victor Rusk

M. D. or other

Address

321 Southview Rd

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1945 - June  
1901 - June  

---

44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83d

## CERTIFICATE OF DEATH

Reg. Dist. No. 11837 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 44 Winters Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

WILLIAM HARRISON MANOKOO

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Violet Manokoo

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) October 4, 18708. AGE: Years 76 Months 2 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Dorchester, Md.  
(Town, county, and state)10. Usual occupation Minister

11. Industry or business

12. Name William H. Manokoo13. Birthplace Md.14. Maiden name Lee Sanders15. Birthplace Md.16. Informant Mrs. Violet ManokooAddress 44 Winters Lane17. Burial Date thereof 12-10-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Zion Cem.Location Baltimore Co., Md.18. Funeral director Mrs. Frances A. HemsleyAddress 578 W. Biddle St.19. 12-9-46 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6<sup>th</sup> 1946 at 9:00 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-16-46 to 12-6-46and that I last saw him alive on 12-6-46

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Right Hemiplegia 20Due to HypertensiveDue to arteriosclerosis?

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Ed. Maloney MD M. D. or other \_\_\_\_\_Address Catonsville Date signed 12-6-46



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11838-301  
Reg. Dist. No.

1. PLACE OF DEATH: Baltimore  
County.....  
City or town.....Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....1 month, 4 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution?.....1 month, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....Maryland..... County.....  
City or town.....Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....1112 S. Clinton St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....-

### 3. (a) FULL NAME

Mary Anna Markiewicz

### 3. (b) Social Security Number

-

4. Sex.....f  
5. Color or race.....w  
6.(a) Single, married, widowed, or divorced.....married

6.(b) Name of husband or wife.....John Markiewicz

6.(c) If alive, give age.....?..... years

7. Birth date of deceased (mo., day, yr.).....January 21, 1885

8. AGE: Years.....61 Months.....11 Days.....9 If less than one day..... hrs. .... min.

9. Birthplace.....Poland  
(Town, county, and state)

10. Usual occupation.....housewife

11. Industry or business.....home

12. Name.....George Poskinski  
13. Birthplace.....Poland

14. Maiden name.....Lena ?

15. Birthplace.....Poland

16. Informant.....Hospital Records  
Address.....Catonsville 28, Md.

17. Burial.....1/13/47  
(Burial, cremation, or removal. Which?).....  
Cemetery or crematory.....St Stanislaus Cemetery

Location.....Dundalk Ave

18. Funeral director.....John J. Duda  
Address.....2829 Hudson St

19. Dec. 31, 19...45.....Q. W. Hedlinski  
(Date rec'd by registrar).....1-25 Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....December 30..... 19...46..... at...7:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Acute Cardiac failure  
Due to.....  
Cardiovascular disease  
Due to.....

Other conditions.....sudden death  
inquiry  
(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?.....

23. SIGNATURE.....Geo. M. Kieffer  
M. D. or other.....  
Address.....1010 Hudson Ave..... Date signed.....12-30-46

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CHANGE OF AGE: CITY HEALTH DEPT. Cert. of birth for deceased #57534 showing corrected date as below changed. **MARYLAND STATE DEPARTMENT OF HEALTH**  
 LL 12-30-46 (Miss H. Krause, 2411 N. Charles St., Baltimore) **CERTIFICATE OF DEATH**  
 Balto. City Health Dept.)

1183330  
 Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Garrison  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? many years (26 yrs)  
 Hospital, institution, or street address where death occurred:  
Home  
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Garrison  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Pleasanttown Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war no

## 3. (a) FULL NAME

William Howard Matthai

## 3. (b) Social Security Number

—

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M.  
 6. (b) Name of husband or wife Charlotte Parker Matthai  
 6. (c) If alive, give age 59 years  
 7. Birth date of deceased (mo., day, yr.) Aug 28, 1882  
 8. AGE: Years 64 Months 3 Days 12 If less than one day  
hrs. min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation Manufacturing  
 11. Industry or business Manufacturing  
 12. Name William Howard Matthai  
 13. Birthplace Baltimore, Md.  
 14. Maiden name Miss Banieft James  
 15. Birthplace Baltimore  
 16. Informant Ralph B. Semler  
 Address 2400 Carson, Conn  
 17. Cremation Date thereof 12-3-46  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Green Mount  
 Location 13 Balto. Md.  
 18. Funeral director Shelton Morris  
 Address 1084 North Ave.  
 19. 12-3 1946 Dr. H. H. H.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2 December 19 46 at 8:15 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
24 Nov 19 46, to 2 Dec 19 46  
 and that I last saw him alive on 2 Dec 46  
 Immediate cause of death Coronary  
embolus  
 Due to Coronary occlusion  
 Due to Arteriosclerosis  
 Other condition none  
 (Include pregnancy within 3 months of death)  
 Major findings of operations none  
 Date of op. ....  
 Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## DURATION

8 days

6 wks.

10 yrs.

22. VIOLENCE: If death was due to external causes, fill in the following: —  
 Accident, suicide, or homicide. Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Paul H. Rouse M.D.  
 M. D. or other  
 Address 211 Church Lane Pikesville, Md. 20846 signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 11840 301

## 1. PLACE OF DEATH:

County 5501 EDMONSTON AVENUE  
 City or town BALTIMORE Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

19-110

How long in hospital or institution?

## 3. (a) FULL NAME

(EMILIE)  
Emilie Marie Weir

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore  
 City or town Baltimore Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE SINGLE

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

1865

8. AGE: Years Months Days If less than one day  
81 - - - hrs. min.

9. Birthplace BALTIMORE, MD.  
(Town, county, and state)10. Usual occupation AT HUTTLERS, DEPT. STORE

11. Industry or business

12. Name JOHN MAXWELL13. Birthplace ?14. Maiden name BRIDGET ?15. Birthplace -16. Informant MR. JOHN ROCHFORDAddress 225 E. 25TH ST.

17. BURIAL Date thereof 12-18-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CATHEDRAL C.E.M.Location CITY18. Funeral director WIEDEFIELD & SONAddress GREENMOUNT AVE & 22ND ST.

19. (Date rec'd by registrar)

12/18/46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1946 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 1946 to Dec 16 1946  
 and that I last saw him alive on Dec 15 1946

Immediate cause of death

Pericardial Hemorrhage

DURATION

2 daysDue to Pericardial Arterio Sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Emilie Marie Weir M. D. or otherAddress Baltimore Date signed 12/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 118414

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 hours  
 Hospital, institution, or street address where death occurred:  
Veteran Hospital FT Howard Md  
 How long in hospital or institution? 3 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3129 Milford Ave  
 (If rural, give LOCATION)  
 2(a) if veteran, name war World War I

## 3. (a) FULL NAME

Frank Edward McGee

## 3. (b) Social Security Number

4. Sex M 5. Color or race wh 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Edna M McGee  
Dec 15 1893 B. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Dec 15 - 1893

8. AGE: Years 53 Months 0 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore  
 (Town, county, and state)

10. Usual occupation Police man

11. Industry or business Baltimore Police Force

12. Name Frank McGee

13. Birthplace Baltimore

14. Maiden name Jenny Higdon

15. Birthplace Baltimore

16. Informant wife

Address 3129 Milford Ave Baltimore

17. Burial Date thereof Jan. 3, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory National Cemetery

Location Baltimore

18. Funeral director Harry Witzke

Address 4101 Edmonson Ave.

19. 1-2 19 46 Antkowiak  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31/46 19 \_\_\_\_\_ at 12:58 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/30/46 19 \_\_\_\_\_ to 12/31/46 19 \_\_\_\_\_  
 and that I last saw him alive on 12/31/46 19 \_\_\_\_\_

Immediate cause of death Cerebral hemorrhage

Due to hypertension

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE P. J. Anderson MD M. D. or other  
 Address Ex Howard Veterans Hospital Date signed 12/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

11842

Reg. Dist. No. 301

## 1. PLACE OF DEATH:

County BaltimoreCity or town Cella  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Cella  
(If outside city or town limits, write RURAL and give nearest town)Street No. 108 Cella Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Albert Henry Medairy

## 3. (b) Social Security Number

?

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Estella C. Medairy

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Oct. 22, 1884

8. AGE:

Years

Months

Days

If less than one day

62

2

7

hrs.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Machinist11. Industry or business Woolen Mill12. Name Wm. A. Medairy

13. Birthplace

Md.14. Maiden name Mary E. Leister

15. Birthplace

Md.16. Informant Estella MedairyAddress Cella, Md.17. Burial Jan. 1, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. JohnsLocation Ellicott City, Md18. Funeral director F. C. HiginbothamAddress Ellicott City, Md.19. (2-3) - 46 Harry H. Miller  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1946 at 5:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 29 1946 to Dec 29 1946and that I last saw him alive on Dec 29 1946

Immediate cause of death

Coronary Arteriosclerosis

DURATION

36 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Ben P. Kahan M. D. or otherAddress Ellicott City, Md Date signed 12/29/46

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JAN 2 1947

BUREAU

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

11843

Reg. Dist. No. 321

1. PLACE OF DEATH:  
County 1703 Frederick Ave.  
City or town Catoctinville Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 12-15  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md. County Bartow  
City or town Catoctinville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1703 Fred. Rd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
Virginia V. Mahan

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct. 28 - 1867  
8. (c) If alive, give age..... years

8. AGE: Years 79 Months 1 Days 15  
If less than one day..... hrs. .... min.

9. Birthplace Va.  
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Daniel Egan  
13. Birthplace Germany

MOTHER 14. Maiden name Barbara Johnson  
15. Birthplace Germany

16. Informant Mrs. Mary Mahan  
Address 1703 Frederick Road

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 12-15-1946  
(month) (day) (year)  
Cemetery or crematory Cathedral Cmn.  
Location Balto. Md.

18. Funeral director George W. Farley  
Address Ford + Shady Nook Ave

19. 12-15-46 (Date rec'd by registrar) Barry D. Miller Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1946, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to 12/12 1946  
and that I last saw h. or alive on 12/12 1946

Immediate cause of death Ab Cerebral Hemorrhage DURATION 12 days

Due to.....

Due to.....

Other conditions Arteriosclerosis 7

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J. P. Alagia M. D. or other

Address 3326 Frederick Ave Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

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BUREAU

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MAINTAIN STATE OF MENTAL HEALTH

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

DEC <sup>6</sup>~~2~~ 1946  
BUREAU V.B.

RECEIVED  
DEC <sup>6</sup>~~4~~ 1946  
BUREAU V.B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

## CERTIFICATE OF DEATH

Reg. Dist. No. 11845 310

<b>1. PLACE OF DEATH:</b> County..... <u>Balto.</u> City or town..... <u>Gwynn Oak Station</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: <u>Franklin Ave</u> How long in hospital or institution?.....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Md</u> County..... <u>Balto</u> City or town..... <u>Gwynn Oak Station</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>Franklin Ave</u> (If rural, give LOCATION) 2.(a) If veteran, name war..... <u>W</u>			
<b>3. (a) FULL NAME</b> <u>Emma Mephham</u>				<b>3. (b) Social Security Number</b> <u>rom</u>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>Roland Mephham</u>				<b>6. (c) If alive, give age</b> ..... years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>May 13<sup>th</sup> 1894</u>				<b>8. AGE:</b> Years..... Months..... Days..... It less than one day..... hrs..... min.			
<b>9. Birthplace</b> <u>Balto. Md.</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Housewife</u>			
<b>11. Industry or business</b> <u>At Home</u>				<b>12. Name</b> <u>John Diehl</u>			
<b>13. Birthplace</b> <u>France</u>				<b>14. Maiden name</b> <u>Caroline (Unknown)</u>			
<b>15. Birthplace</b> <u>France</u>				<b>16. Informant</b> <u>Roland Mephham</u> Address <u>Gwynn Oak Station Balto. 7</u> <u>Burial</u> Date thereof..... <u>12/23/46</u> (Burial, cremation, or removal: Which?) (month) (day) (year) Cemetery or crematory..... <u>Woodlawn</u> Location..... <u>Md.</u>			
<b>17. Funeral director</b> <u>William Cook Inc.</u> Address <u>1217 St. Paul st.</u>				<b>18. (Date rec'd by registrar)</b> <u>12/23 46</u>			
<b>19. (Date rec'd by registrar)</b> <u>12/23 46</u>				<b>20. DATE OF DEATH</b> <u>Dec 20<sup>th</sup> 1946</u> at <u>Noon</u>			
<b>21. I CERTIFY that death occurred on the date above stated that I attended deceased from</b> <u>Jan 1 6</u> 19 <u>46</u> to <u>Dec 20 46</u> and that I last saw him alive on <u>Dec 19</u> 19 <u>46</u>				<b>MEDICAL CERTIFICATION</b> Immediate cause of death..... <u>Carcinoma Breast</u> Due to..... <u>General carcinoma</u> Due to..... <u>Breast &amp; Abdomen</u> Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... <u>Carcinoma Breast</u> <u>2 years ago</u> Date of op..... Autopsy results..... <u>none</u> PHYSICIAN: Please underline the cause to which death should be charged statistically.			
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work?				<b>23. SIGNATURE</b> <u>John H. Mapham M.D.</u> Address..... <u>1219 Capital Ave</u> Date signed..... <u>12/23/46</u>			



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

11846

## 1. PLACE OF DEATH

County BaltimoreVillage or City CatonsvilleRegistration Dist. No. 301No. 6 Wade Ave

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 86 yrs. 4 mos. 21 ds. How long in U.S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.2. FULL NAME Elmira V. Middlekamp U. S. Veteran, specify WAR \_\_\_\_\_(a) Residence: No. 6 Wade Ave

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed5a. If married, widowed, or divorced  
HUSBAND of (or) WIFE of John H. Middlekamp6. DATE OF BIRTH (month, day, and year) July 17-18607. AGE Years 86 Months 4 Days 21 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BDDKKEEPER, etc. Home Duties  
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month end year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_12. BIRTHPLACE (city or town) Baltimore Md  
(State or country)13. NAME John P. Mc Donald14. BIRTHPLACE (city or town) Scotland  
(State or country)15. MAIDEN NAME Catherine FitzPatrick16. BIRTHPLACE (city or town) Ireland  
(State or country)17. INFORMANT Mrs. Elmira V. Clabough  
(Address) 6 Wade Ave Catonsville18. BURIAL, CREMATION, OR REMOVAL Burial  
Place St. Johns Cem. Date Dec 11, 194619. UNDERTAKER Ignatie Cook Syfer  
(Address) 1500 W. North Ave20. FILED 12-10-46 Registrar \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

December 8 1946  
(Month) (Day) (Year)22. I HEREBY CERTIFY, That I attended deceased from June 1942 to December 8, 1946I last saw her alive on Dec 7, 1946; death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

Myocarditis

Other Contributory Causes of Importance:

arteriosclerosisName of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIDLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of Injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) North Star Fort(Address) 20 S. Preston St - Baltimore



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

*Arteriosclerosis*

*Chronic interstitial nephritis*

*Cerebral hemorrhage*

Date of onset

*1915*

*1921*

*July 5, 1927*

Other contributory causes of importance:

*Gallstones*

*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:

*Attack of epilepsy*

*Run over by street car*

*Peritonitis*

Date of onset

*1 week ago*

*1 week ago*

*3 days ago*

Other contributory causes of importance:

*Gastroenteritis*

*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

## 1. PLACE OF DEATH:

County Baltimore  
 City or town 47 Bloombsbury Patons, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 47 Bloombsbury Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Caroline M. Miller

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Henry C. F. Miller

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1866  
 8. AGE: Years 80 Months 4 Days 16 If less than one day hrs. min.

9. Birthplace Marietta, Pa.  
 (Town, county, and state)

10. Usual occupation Household duties11. Industry or business Own home12. Name Adam Schwaartzkopf13. Birthplace Usherach, Russia, Germany14. Maiden name Jaboci E. Stump15. Birthplace Haldenheim, Germany16. Informant Miss Julia MillerAddress 47 Bloombsbury Ave Catons17. Burial Date thereof Dec 26, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory New Cathedral AveLocation Old Frederick Rd, Balt, Md18. Funeral director Easton SonsAddress 608 Frederick Ave, Catons19. 12-25- 46 Harry D. Miller  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23, 1946 at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5- 1931 to Dec 23, 1946  
 and that I last saw her alive on Dec 23, 1946

Immediate cause of death Chr. Myocarditis DURATION 15 yrs.Due to PronouncedDue to Chronic Myocarditis 15 yrs.Due to Chronic Coronary disease 15 yrs.Other conditions Intermittent asthma 8 yrs.Major findings of operations Acute Cholelithiasis

PHYSICIAN: Please endorse the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

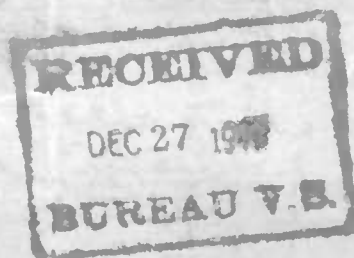
Means of injury Injured at work?

23. SIGNATURE A. M. Heuring, M.D.203 - Includes an 12-24-46Address Catonsville Date signed Dec 28

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 years 5 months, 29 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 8 years 5 months 29 days.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County.....  
 City or town... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 809 South East Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... 10 ✓

## 3.(a) FULL NAME

William J. Moody

## 3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife None  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) January 27, 1870  
 8. AGE: Years Months Days If less than one day  
76 10 17 ..... hrs. .... min.

9. Birthplace Baltimore Maryland  
 (Town, county, and state)

10. Usual occupation None

11. Industry or business "

FATHER 12. Name William Moody

13. Birthplace Massachusetts

MOTHER 14. Maiden name Mary A. Brown

15. Birthplace Maryland

16. Informant Hospital records,

Address Catonsville, 28, Maryland

17. Christ Date thereof 12/17/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park

Location Catonsville, Md

18. Funeral director William G. Smith

Address 1214 S. Bond St

19. 12-16 ES Dec 17 1946  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1946 at 6:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18, 1938 to December 14, 1946  
 and that I last saw him alive on December 14, 1946

Immediate cause of death Acute cardiac infarction DURATION 1 hour

Due to Chronic Coronary disease Indefinite

Due to Chronic hypertensive C-V disease "

Other conditions hepatic cirrhosis, cystic kidney disease; arrested pulm. tbc. "  
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Henry C. A. Mead, M.D.

Henry C. A. Mead, M. D. M.D. or other  
 Address Catonsville, 28, Md. Date signed 12/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11849

Reg. Dist. No. 330

## 1. PLACE OF DEATH:

County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs 5 mosHospital, institution, or street address where death occurred:  
Dolfield Rd Owings MillsHow long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)Street No. Dolfield Road  
(If rural, give LOCATION)2.(a) If veteran, name war No

## 3. (a) FULL NAME

Priscilla Shorb Moser

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

W8.(b) Name of husband or wife John B MoserB.(c) If alive, give age                      years7. Birth date of deceased (mo., day, yr.) July 19 1870

8. AGE:

Years 76Months 5Days 7

If less than one day

                     hrs.                      min.9. Birthplace Carroll County Md  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business -12. Name - Shorb13. Birthplace Frederick County Md14. Maiden name Elizabeth Stambaugh15. Birthplace Frederick County Md16. Informant Mrs Fred. BatesAddress Owings Mills Md17. Burial Date thereof Dec 29 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Westminster CemeteryLocation Westminster Md18. Funeral director Wm Berryman & SonsAddress Reisterstown Md19. 12-27- 1946 Mary B. E. Line  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/46 at 12 M M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/1/46 to 12/26/46 and that I last saw cert alive on 12/25/46

Immediate cause of death

myocarditis - chronic decompensating hypertension arteriosclerosis

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide                      Date of                     Where did injury occur?                      (City or town) (County) (State)Injured at home, farm, industry, public place (where?)                     Means of injury                      Injured at work?                     23. SIGNATURE John B. Saffell M. D. or other                       
Address Reisterstown Md Date signed 12/26/46



UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DEATH OF

NAME

AGE

DATE OF DEATH

RECEIVED  
DEC 30 1946  
BUREAU V B

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore <sup>30d</sup>

## CERTIFICATE OF DEATH

11850

Reg. Dist. No. <sup>44</sup>

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 42 days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Fort Howard, Maryland  
How long in hospital or institution? 42 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County   
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 428 N. Caroline St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war WW -I

### 3. (a) FULL NAME

GEORGE MOSES, JR.

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Margaret Moses

6. (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) September 15, 1898

8. AGE: Years 48 Months 3 Days 3 If less than one day  hrs.  min.

9. Birthplace Darlington, South Carolina  
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name George Moses  
13. Birthplace South Carolina

MOTHER 14. Maiden name Lucy Gandy  
15. Birthplace South Carolina

16. Informant Clinical Records Vets. Adm. Hosp.  
Address Fort Howard, Maryland

17. Burial Date thereof 12-23-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory   
Location Florence, S. C.

19. Funeral director Charles F. Law  
Address 802 S. Mad. Ave.

19. 12/20 19 46 A. W. Hedrick  
(Date reported by registrar) (year) (month) (day) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 19 46 at 5:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 19 46 to December 18 19 46 and that I last saw him alive on December 18 19 46

Immediate cause of death SYPHILITIC ANEURYSM OF AORTA WITH RUPTURE

DURATION Acute  
2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury  Injured at work?

Signature Robert M. Cullison  
23. SIGNATURE R. M. CULLISON, M.D. CLIN. DIR.  
M. D. or other

Address VAH FT. HOWARD, MD. Date signed 12-19-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11851

301

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Balto.City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

416 Ingleside Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 416 Ingleside Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

CHARLES E. PIERCE

## 3. (b) Social Security Number

no

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

--

## 6. (c) If alive, give age

years

## 7. Birth date of

deceased (mo., day, yr.)

Sept. 5, 1873

## 8. AGE:

Years

Months

Days

If less than one day

7332

.....hrs. ....min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Stone Mason

## 11. Industry or business

Self

FATHER

## 12. Name

Emmanuel Pierce

## 13. Birthplace

Md.

MOTHER

## 14. Maiden name

Alice Tripplett

## 15. Birthplace

Md.

## 16. Informant

Mrs. Edith White, sister

## Address

2101 W. North Ave.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

12/11/46

(month) (day) (year)

## Cemetery or crematory

Wards Chapel

## Location

Liberty Rd.

## 18. Funeral director

WM. J. TICKNER & SONS

## Address

Balto., Md.

## 19. (Date rec'd by registrar)

12-10-46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1946 at 10:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 22, 1946 to Dec 7, 1946  
and that I last saw him alive on Dec 7, 1946

## Immediate cause of death

## DURATION

Coronary Thrombosis12 hrs.

## Due to

Acute Gastritis24 hr. ?

## Due to

Latent54 hr. ?

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

George Urban  
Catonsville 38 MA

M. D. or other

Date signed 12-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 782

## CERTIFICATE OF DEATH

Reg. Dist. No. 11852

## 1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Percy Pittman

4. Sex

M

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Elizabeth Pittman

7. Birth date of

deceased (mo., day, yr.)

December 6, 1904

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

42011

hrs.

min.

9. Birthplace

Rocky Mount, N. C.  
(Town, county, and state)

10. Usual occupation

Steel Worker

11. Industry or business

Bethlehem Steel Corp.

12. Name

unknown

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Mrs. Elizabeth Pittman

Address

918 Madison Avenue17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12-26-46

(month) (day) (year)

Cemetery or crematory

Int. Ambrose Cem.

Location

Baltimore, Maryland

18. Funeral director

Charles E. Law

Address

802 Madison Avenue19. 12-17-46

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 918 Madison Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec. 17 19 46 at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Acute Pulmonary EdemaDue to Chronic MyocardialDysrhythmiaDue to Regulation

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. O. Davis M.D.Address Baltimore, Md. Date signed 12/17/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11853

## CERTIFICATE OF DEATH

Reg. Dist. No.

4-2

## 1. PLACE OF DEATH:

County Balto.City or town Halethroe  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

1800 Park Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Halethroe  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1800 Park Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

HENRY DAVID PLACK

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of ~~husband~~ wife Elinor L. Plack

7. Birth date of

deceased (mo., day, yr.)

July 26, 1880

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

66424

hrs.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual occupation Salesman11. Industry or business Daniel Miller & Co.12. Name Louis H. Plack13. Birthplace Baltimore14. Maiden name Ann Barbara Appey15. Birthplace Va.16. Informant Mr. Paul L. PlackAddress 1800 Park Ave. Halethroe17. Burial

(Burial, if not in place of death, write place)

Date thereof 12/23/46

(month) (day) (year)

Cemetery BaltimoreLocation Baltimore, Md.18. Funeral director WM. J. TICKNER & SONS INC.Address NORTH & PA. AVES. BALTO. 17, Md.19. 12/23/46  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1946 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1945 to Dec 20 1946  
and that I last saw him alive on Dec 20 1946

Immediate cause of death

Coronary Thromboses

DURATION

1 yr.

Due to

Arterio Sclerosis1 yr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. J. Tickner

M. D. or other

Address 1711 Selma Ave. Balto 27 Date signed 12/24/46

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

## CERTIFICATE OF DEATH

11854

Reg. Dist. No. 301

1. PLACE OF DEATH: Baltimore  
 County.....  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years, 1 month, 3 days  
 Hospital, institution, or street address where death occurred:  
 Spring Grove State Hospital  
 How long in hospital or institution? 30 years, 1 month, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland..... County..... Baltimore  
 City or town..... Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .... W. Chesapeake Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mary Elizabeth Pocock

## 3. (b) Social Security Number

-

4. Sex..... female  
 5. Color or race..... white  
 6.(a) Single, married, widowed, or divorced..... Widowed

8.(b) Name of husband or wife..... ~~unk-~~ Phillip Henry Pocock

7. Birth date of deceased (mo., day, yr.)..... September 25, 1866  
 6.(c) If alive, give age..... years

8. AGE: Years..... 80 Months..... 2 Days..... 17  
 If less than one day..... hrs. .... min.

9. Birthplace..... Maryland  
 (Town, county, and state)

10. Usual occupation..... housewife

11. Industry or business..... home

12. Name..... Stephen Phillips

13. Birthplace..... Maryland

14. Maiden name..... Lucretia Arthur

15. Birthplace..... Maryland

18. Informant..... Hospital Records

Address..... Catonsville 28, Maryland

17. Burial..... Date thereof..... December 15, 1946  
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Ebenezer Cemetery

Location..... Harford County, Maryland

18. Funeral director..... John Burns' Sons

Address..... Towson, Maryland

19. p/13 x6 4w Hedrick  
 (Attended by registrar)..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 12..... 19.. 46.. at 6:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 November 9..... 19.. 46.. to December 12..... 19.. 46..  
 and that I last saw h. her live on December 12..... 19.. 46..

Immediate cause of death.....  
 Hypertensive cardiovascular  
 disease.

DURATION  
 Indef.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results..... no  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature.....  
 Catonsville 28, Md.

23. SIGNATURE..... M. D. or other

Address..... Date signed..... 12/12/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11855

Reg. Dist. No. 444

<b>1. PLACE OF DEATH:</b> County..... <u>Baltimore</u> City or town..... <u>Baltimore 711 Old North Point Rd.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Md.</u> County..... City or town..... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>711 Old North Point Road</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Mary S. Persinger</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Female</u> <b>5. Color or race</b> <u>White</u> <b>6. (a) Single, married, widowed, or divorced</b> <u>Widow</u>				<b>MEDICAL CERTIFICATION</b>			
<b>6. (b) Name of husband or wife</b> <u>Frederick Persinger</u>				<b>20. DATE OF DEATH</b> <u>Dec 26</u> 19 <u>46</u> , at <u>4 27 P.</u>			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Nov. 12, 1856</u> <b>8. (c) If alive, give age</b> ..... years				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Dec 15</u> 19 <u>46</u> to <u>Dec 26</u> 19 <u>46</u> and that I last saw her alive on <u>Dec 26</u> 19 <u>46</u>			
<b>8. AGE:</b> Years <u>90</u> Months <u>1</u> Days <u>14</u> If less than one day ..... hrs. .... min.				<b>Immediate cause of death</b> <u>Coronary Thrombosis</u> <b>DURATION</b> <u>1 day</u>			
<b>9. Birthplace</b> <u>Balto. Md.</u> (Town, county, and state)				<b>Due to</b> <u>Myocardium</u>			
<b>10. Usual occupation</b> <u>Housewife</u>				<b>Due to</b> <u>arterio-sclerosis</u>			
<b>11. Industry or business</b> <u>at home</u>				<b>Other conditions</b> <u>✓</u>			
<b>12. Name</b> <u>John Walton</u>				(Include pregnancy within 3 months of death)			
<b>13. Birthplace</b> <u>Baltimore, Md.</u>				<b>Major findings of operations</b>			
<b>14. Maiden name</b> <u>Unknown</u>				Date of op.			
<b>15. Birthplace</b> <u>Baltimore, Md.</u>				<b>Autopsy results</b>			
<b>16. Informant</b> <u>Ida Filkins</u>				<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>Address</b> <u>711 Old North Point Road</u>				<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>			
<b>17. Burial</b> <u>Burial</u> <b>Date thereof</b> <u>Dec. 30, 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year)				<b>Accident, suicide, or homicide</b> ..... <b>Date of</b> .....			
<b>Cemetery or crematory</b> <u>Capequon</u>				<b>Where did injury occur?</b> ..... (City or town) (County) (State)			
<b>Location</b> <u>Eastern Ave.</u>				<b>Injured at home, farm, industry, public place (where?)</b> .....			
<b>18. Funeral director</b> <u>Wm. Cook Inc.</u>				<b>Means of injury</b> ..... <b>Injured at work?</b> .....			
<b>Address</b> <u>1217 St. Paul St.</u>				<b>23. SIGNATURE</b> <u>M. A. Jacobs</u> <b>M. D. or other</b> <u>Ins</u>			
<b>19. 12/28</b> 19 <u>46</u> <u>A. H. Heflich</u> (Date rec'd by registrar) Registrar				<b>Address</b> <u>617 North St</u> <b>Date signed</b> <u>12/26/46</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. *1185410*

## 1. PLACE OF DEATH:

County BaltimoreCity or town Colgate

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

WILLIAM C. POST

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Frieda Post6. (c) If alive, give age 51 years7. Birth date of deceased (mo., day, yr.) July 28, 1892

8. AGE:

54

Years

Months

4

Days

19

If less than one day

hrs.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Supt. Broom works

11. Industry or business

12. Name William Post,13. Birthplace Germany14. Maiden name Caroline Dietz15. Birthplace Germany16. Informant Mrs. Frieda PostAddress 7105 Eastern Ave.17. Burial Date thereof Dec. 20, 1946

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory First United Evan. Cemetery.Location Baltimore, Md.18. Funeral director Ulrich Funeral HomeAddress 2008 Orleans St.m19. 12/20/46 Registrar

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Colgate

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7105 Eastern Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Decemembr 17, 19 46 at 5:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 19 46 to Dec 17 19 46and that I last saw him alive on Dec 16 19 46

Immediate cause of death

Lymphosarcoma of the Left Kidney

DURATION

3 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Lymphosarcoma of the Left KidneyDate of op. about Oct 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Louis J. Kroll MD

M. D. or other

Address 1801 Eutan Place Date signed 12/17/46

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County

Village or City

No.

Registration Dist. No.

St.

Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDDED,  
OR DIVORCED (write the word)5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than

1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.10. Date deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE (city or town)  
(State or country)

FATHER

13. NAME

14. BIRTHPLACE (city or town)  
(State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town)  
(State or country)17. INFORMANT  
(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. UNDERTAKER  
(Address)

20. FILED

19

Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

(Month)

(Day)

19

22. I HEREBY CERTIFY, That I attended deceased from  
Sept 36, 1946, to Dec 13, 1946I last saw him alive on Dec 13, 1946; death is said  
to have occurred on the date stated above, at 7 P. M.THE PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Arteriosclerosis  
Cardiovascular disease

Date of onset

Sept. 1946

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

Charles H. T. Perer M. D.

(Address) 6701 York Rd Balto Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 11858 3/10 P

1. PLACE OF DEATH: *Baltimore Co.*County *Augusta ave.*City or town *Bundale*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *md.* CountyCity or town *Baltimore*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *2406 Fair Avenue*  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

*Joseph Racznick*

## 3.(b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Widowed*6.(b) Name of husband or wife *Anna Racznick*7. Birth date of deceased (mo., day, yr.) *1867*

6.(c) If alive, give age years

8. AGE: Years *79* Months Days If less than one day  
hrs. min.9. Birthplace *Poland*  
(Town, county, and state)10. Usual occupation *Laborer*

11. Industry or business

12. Name *Joseph Racznick*13. Birthplace *Poland*

14. Maiden name

15. Birthplace *Poland*

16. Informant

Address

17. *Burial* Date thereof *Dec. 28, 1946*  
(Burial, cremation, or removal, Which) (month) (day) (year)Cemetery or crematory *Holy Rosary*Location *Baltimore*18. Funeral director *Fred W. Ozagowski*Address *1930 Eastern Avenue*19. *Dec. 27* 19 *46* *A. W. Hersh*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 25-* 19 *46* at *3:30 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death *Coronary Occlusion*Due to *A-S-C-V Disease*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *NO* Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *M. Boavos M.D.*Address *10 D. or other*Date signed *1/1/47*

11859

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 138

## CERTIFICATE OF DEATH

Reg. Dist. No. 400

## 1. PLACE OF DEATH:

County BaltimoreCity or town Nokh Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Nokh Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sister Mary Adrienne Roberto

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

June 22, 1903

## 8. AGE:

Years

Months

Days

If less than one day

43519

hrs.

min.

## 9. Birthplace

Boston Mass.

(Town, county, and state)

## 10. Usual occupation

Teacher

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Sy. Prester Roberto

## 13. Birthplace

Italy

## 14. Maiden name

Carmelita Morana

## 15. Birthplace

Italy

## 16. Informant

Sr. Mary Clara

## Address

Nokh Cliff, Md.

## 17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Dec 13 / 46

## Cemetery or crematory

St. John's Califf.

## Location

St. John's Califf.

## 18. Funeral director

## Address

Rev M. F. Smith Son  
811 N. Wolfe St.

## 19. Date rec'd by registrar

12/12/46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1946 at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 13 1946 to Dec 11 1946and that I last saw him alive on Nov 26, 1946 1946Immediate cause of death Pulmonary Tuberculosis

## DURATION

since 1929

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Dec 12 / 46

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

DEC 21 1946

BUREAU

2-35-



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

11860

381

### 1. PLACE OF DEATH:

County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 7311 York road  
(If rural, give LOCATION)  
2(a) If veteran, name war World War #1

### 3. (a) FULL NAME

HARRY A. RODDY

### 3. (b) Social Security Number

705-09-0011

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lillian Roddy

6. (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1888

8. AGE: Years 58 Months 1 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Auditor

11. Industry or business B. & O. R.R.

12. Name John J. Roddy

13. Birthplace Ireland

14. Maiden name Maria N.

15. Birthplace Ireland

16. Informant Mrs. Lillian Roddy  
Address 7311 York road

17. Burial Date thereof 12/28/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral

Location Chas. J. Evans, Son, Inc.

18. Funeral Director 118 N. Mt. Pleasant Ave.

Address 118 N. Mt. Pleasant Ave.

19. Dec 28 19 46  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 19 46 at \_\_\_\_\_ M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 41 to Dec 24 19 46 and that I last saw him alive on Dec. 24 19 46.

Immediate cause of death Hyper tension. cardio-vascular. Renal disease.  
DURATION 5 YRS - 1 YR.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death).

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

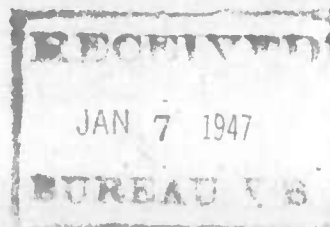
23. SIGNATURE Chas. J. Evans, Son, Inc.  
Address 507 York Rd. Date signed 12/26/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

DR. CALFOZZA  
5217 YORK ROAD



2-25

2-380- 2-10

Evidence for the change of  
name of wife is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

## CERTIFICATE OF DEATH

Reg. Dist. No.

G 108 12/17/46

11861

440

### 1. PLACE OF DEATH:-

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 111 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Ft. Howard, Maryland  
How long in hospital or institution? 111 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 423 E. 25th Street  
(If rural, give location)  
2. (a) If veteran, name war WW-I

### 3. (a) FULL NAME

THOMAS D. ROWLENSON

### 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Mrs. Nellie A. Smith Rowlenson  
7. Birth date of deceased (mo., day, yr.) 1-13-83 6. (c) If alive, give age ..... years  
8. AGE: Years 63 Months 10 Days 26 If less than one day ..... hrs. .... min.

9. Birthplace Sherwood, Maryland  
(Town, county, and state)  
10. Usual occupation Unemployed  
11. Industry or business  
FATHER 12. Name William T. Rowlenson  
13. Birthplace Maryland  
MOTHER 14. Maiden name Mary Sewell  
15. Birthplace Maryland

16. Informant Registrar's Office, Clin. Records  
Address Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial 12/12/46  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
Cemetery or crematory Baltimore National Cemetery  
Baltimore, Maryland  
Location

18. Funeral director Wm. Cook & Son  
Address St. Paul & Preston Sts., Balto., Md.

19. 12-10-46 19 46 Protestant  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20, 1946 to December 9, 1946  
and that I last saw him alive on December 9, 1946

Immediate cause of death UREMIA  
DURATION 6 Weeks plus

Due to Chronic Glomerular nephritis

Due to

Other conditions Hypertension, arterial 20 Yrs. plus  
Hypertensive Heart disease Undet.  
Chr. Pulmonary tuberculosis left upper lobe  
Major findings of operations Duration --- 25 Yrs. plus.

Date of op.

Autopsy results No Autopsy  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. M. CULLISON, M.D. CLIN. P. Officer

Address V.A. ET. HOWARD, MD. Date signed 12-9-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82a)

11862

P

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

### 1. PLACE OF DEATH:

County..... Baltimore  
City or town..... Westowne  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 1 Yr.  
Hospital, institution, or street address where death occurred: Hood Nursing Home  
5313 Edmondson Ave.,  
How long in hospital or institution?..... 1 Yr.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Md. County..... Baltimore  
City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3925 Edmondson Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name War.....

### 3. (a) FULL NAME

Nellie Scheu

### 3. (b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

8.(b) Name of husband or wife John C. Scheu

7. Birth date of deceased (mo., day, yr.) May 29, 1878

8. AGE: Years Months Days If less than one day  
68 6 6 hrs. min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Joseph Belt

13. Birthplace Baltimore, Md.

14. Maiden name Elizabeth Carroll

15. Birthplace Baltimore, Md.

16. Informant Mrs. O. Willard Barnes

Address 3925 Edmondson Ave.,

17. Burial Date thereof 12-9-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory xxxx Loudon Park

Location Baltimore, Md.

18. Funeral director J. Howard Strong

Address 3207 W. North Ave.,

19. 12-9-46 19 46  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

12.40

2D. DATE OF DEATH December 5, 1946 at D. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19. 46 to Dec. 5 19. 46  
and that I last saw him alive on Dec. 5 19. 46

Immediate cause of death Cerebral hemorrhage  
DURATION 2 days

Due to arterio sclerosis one year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

H.W. SCHEYE

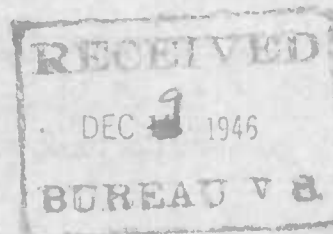
23. SIGNATURE M. D. or other

Address 3925 Edmondson Ave. Date signed 12-6-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 118330

## 1. PLACE OF DEATH:

County BALTIMORECity or town CATONSVILLE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

White PRIVATE HOMEHow long in hospital or institution? EDMONSONY NUNNERY LANE

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD CountyCity or town BALTIMORE  
(If outside city or town limits, write RURAL and give nearest town)Street No. 136 WEBER ST.  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

HENRY SCHLEEF

## 3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife MARIA SCHLEEF

6. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) NOT KNOWN 1876

8. AGE: Years Months Days If less than one day

about 75 hrs. min.9. Birthplace GERMANY.  
(Town, county, and state)10. Usual occupation RETIRED

11. Industry or business

12. Name NOT KNOWN13. Birthplace GERMANY.14. Maiden name NOT KNOWN15. Birthplace GERMANY.16. Informant HOME RECORD

Address

17. BURIAL Date thereof DEC 11-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HOLY CROSS CEM.Location A.A. Co18. Funeral director Bernard B. HaleAddress 121 E WEST ST.19. 12-10-46 19 46 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH DEC - 8th 1946 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/26 1946 to 12/8 1946and that I last saw him alive on 12/1 1946Immediate cause of death Lenticular StriateRupture of artery DURATION shortDue to hypertension artery unknownDue to general arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ellison M. D. or otherAddress 107 E. WYOMING Date signed 12/9/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11864

Reg. Dist. No. 301

1. PLACE OF DEATH: Baltimore  
 County.....  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 years, 8 months, 28 days  
 Hospital, institution, or street address where death occurred:  
 Spring Grove State Hospital  
 How long in hospital or institution? 5 years, 8 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1911 E. Pratt Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Gustave Schmidt

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) December 11, 1882  
 6.(c) If alive, give age..... years

8. AGE: Years 64 Months Months Days 15 If less than one day..... hrs. .... min.

9. Birthplace..... Germany  
 (Town, county, and state)

10. Usual occupation..... barber

11. Industry or business..... business for himself

12. Name..... Gustave Schmidt

13. Birthplace..... Germany

14. Maiden name..... Bertha Rabin

15. Birthplace..... Germany

16. Informant..... Hospital records

Address..... Catonsville 28, Md.

17. Burial Date thereof..... 12/30/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetary or crematory..... Sacred Heart

Location..... German Hill Rd.

18. Funeral director..... Kelly &amp; Zeeb

Address..... 403 S. D. St.

19. Dec 26 19 46 A 24. Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 19 46 at 1:45a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 19 41 to December 26 19 46 and that I last saw him alive on December 26 19 46

Immediate cause of death..... Chronic myocardial failure  
 Indef.

Due to..... Chronic arteriosclerotic cardiovascular disease  
 Indef.

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... Henry C. Mead M.D.

Address..... Catonsville 28, Md.

Date signed..... 12/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-2)

## CERTIFICATE OF DEATH

(★) 11865

Reg. Dist. 150

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 Days

Hospital, institution, or street address where death occurred:

Vets. Hosp. Fort Howard, Md.How long in hospital or institution? 70 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2635 Greenmount Avenue  
(If rural, give LOCATION)2. (a) If veteran, name war Retired

## 3. (a) FULL NAME

WILLIAM H. SCHOFIELD

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single6. (c) If alive, give age  years7. Birth date of deceased (mo., day, yr.) 9 - 1 - 1884

8. AGE: Years 62 Months 3 Days 3 If less than one day  hrs.  min.

9. Birthplace Orangeville, Maryland  
(Town, county, and state)10. Usual occupation Retired11. Industry or business U. S. Army12. Name H. C. Schofield13. Birthplace Maryland14. Maiden name Rebecca Evans15. Birthplace Maryland16. Informant Clinical Records, Vets. Hosp.Address Ft. Howard, Md.17. Burial Date thereof 12-7-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Wiedefeld & SonAddress Balto., Md.19. 12/6/46 (Date rec'd by registrar) 1-38 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1946, at 7:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25, 1946 to December 4, 1946, and that I last saw him alive on December 4, 1946.

Immediate cause of death Petechial hemorrhage in brain stem; hyperemia of brain

## DURATION

3 DaysDue to Due to Other conditions Cerebral atrophy

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE Paul Padget

PAUL PADGET, ACT. CLIN. DIR. M.D. or other

Address V.A. FT. HOWARD, MD. Date signed 12-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

## CERTIFICATE OF DEATH

11866

Reg. Diat. No. 440

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Fort Howard, Maryland  
 How long in hospital or institution? 24 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Baltimore Denton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 304 Church St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war W.W.II ✓

## 3. (a) FULL NAME

JOHN G. SIMMS

## 3. (b) Social Security Number

218-05-8302

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Single

6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 3/27/1902 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years Months Days If less than one day  
44 8 27 hrs. min.

9. Birthplace Oak Grove, Delaware  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Judge Simms

13. Birthplace Dorchester Co., Md.

MOTHER 14. Maiden name Picilla Sciffert

15. Birthplace Carolina Co., Md.

16. Informant Clinical Records Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Buried Date thereof Dec. 28, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul Cemetery

Location near Federalsburg, Md.

18. Funeral director J. J. Frampton & Son

Address Federalsburg, Maryland

19. Dec 26 - 46 Dawson J. Harbo  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 24, 1946 at 9:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 30, 1946 to December 24, 1946

and that I last saw him alive on December 24, 1946

Immediate cause of death CORONARY OCCLUSION  
ACUTE DURATION Sudden

Due to Heart Disease, Hypertension and Coronary Arteriosclerosis, Cardiac

Due to Enlargement, Myocardial Insufficiency 2 months plus

Other conditions Nephritis, Chronic with Uremia 2 months plus  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

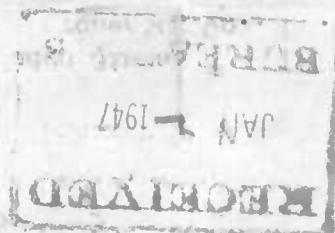
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. E. Newnam, M.D. M. D. or other

Address V.A.H. Ft. Howard, Md. Date signed 12/24/46

Authorization for change of address - by phone to the Clinical Records Dept.  
at the Vets. Adm. Hosp. Fort Howard, 1-16-47. ams.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH11867  
Registered No. 41

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 303 Tompkins Court, (Sollers Home)

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County BALTO

(c) City or town BALTIMORE - COUNTY  
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

3 (a) FULL NAME HATTIE SKINNER

3 (b) If veteran, name war

3 (c) Social Security Account  
No.

4. Sex

FEMALE

5. Color or race

Colored

6 (a) Single, married, widowed, or  
divorced. Widowed

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JANUARY 12, 1880

8. AGE:

Years 66

Months 11

Days 13

If less than one day

hr.

min.

9. Birthplace EASTVILLE, VA

(Town, county, and state)

10. Usual Occupation COOK

11. Industry or business

12. Name DANIEL CUSTER HUNT

13. Birthplace EASTVILLE, VA.

14. Maiden Name SALLIE BAKER

15. Birthplace RICHMOND, VA.

16 (a) Informant DANIEL C. HUNT

(b) Address 1607 W. Mulberry Street

17 (a) Burial (b) Date thereof 12-30-46  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Calverton Mem. Park

Location Balto County

18 (a) Funeral director Isaac L. Brown &amp; Son

(b) Address 1800 W. Montgomery St.

19 (a) Dec. 30-46 (b) R. St. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1946 at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 7, 1946, to Dec. 25, 1946, and that I last saw her alive on Dec. 25, 1946.

Immediate cause of death

Duration

CORONARY OCCLUSION  
Due to Hypertensive HEART  
Disease

4 hrs

Several Months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

## PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard H. Hunt  
Address 1607 W. Mulberry St. Date signed 12/27/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

11869

Reg. Dist. No.

3015

## 1. PLACE OF DEATH

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Old Fred Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Smith

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Fwwidow6. (b) Name of husband or wife Daniel

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 29 1956

8. AGE:

Years

Months

Days

If less than one day

90226hrs.min.

9. Birthplace

Baltimore Md  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

LI

MOTHER

14. Maiden name

LI

15. Birthplace

LI

16. Informant

Baltimore Co. Welfare Board

Address

Towson Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore Maryland

18. Funeral director

Address

F. C. Higginbotham  
Ellicott City Md

19.

(Date rec'd by registrar)

19

46Stamp: [Signature]

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 25

19

46at 7 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1

19

46to Dec 25

19

46

and that I last saw h

or

19

Dec 24

19

46

Immediate cause of death

Cerebral thrombosis

DURATION

2 days

Due to

Cerebral arterio sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

[Signature]

M. D. or other

Address

Catonsville

Date signed

12/29



ARTESIAN (1946)

RAG CONTROL

RECEIVED  
DEC 31 1946  
BUREAU OF

1-35

2-301 ————— 1 — 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

## CERTIFICATE OF DEATH

Reg. Dist. No. 11870 101

## 1. PLACE OF DEATH

County BaltimoreCity or town Hyde - Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Hyde - Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Laura V Sotdorus

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Gebery Sotdorus

## 7. Birth date of deceased (mo., day, yr.)

July 13 - 1874

## 6. (c) If alive, give age

75 years

## 8. AGE:

Years

Months

Days

If less than one day

72510

hrs.

min.

## 9. Birthplace

Maryland  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

William Frisun

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Isadora Wilson

## 15. Birthplace

Maryland

## 16. Informant

Mrs Norman Spahr

## Address

Belair, Md

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

12-26-46  
(month) (day) (year)

## Cemetery or crematory

Greenwood

## Location

Balto Co. Md

## 18. Funeral director

Edw O Tipton

## Address

28 Hampstead Md

## 19.

(Date rec'd by registrar)

19

46

G. E. Arthur  
Spahr Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 19 46, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 23 19 46, to Dec. 23 19 46and that I last saw him alive on Dec. 23 19 46

Immediate cause of death

Coronary Thromb.

## DURATION

10.15 in

Due to

Myocardial Infarction

Due to

Diabetes

Other conditions

Myocardial Infarction

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Clifford F. Hudson MD  
Fork MD M. D. or other  
Address \_\_\_\_\_ Date signed 12/24/46

RECEIVED

DEC 30 1946

BUREAU VS

2-25

2-400 - 2-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12563

Reg. Dist. No. 32

### 1. PLACE OF DEATH:

County Baltimore  
City or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 mos., 20 days  
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T.B. Sanatorium  
How long in hospital or institution? 4 mos., 20 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3546 Horton Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war.

### 3. (a) FULL NAME

Charles Michael Spioch

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sophia M. Spioch  
6. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) September 13, 1880  
8. AGE: Years 66 Months 3 Days 12 It less than one day hrs. min.

9. Birthplace Austria  
(Town, county, and state)

10. Usual occupation Storekeeper

### 11. Industry or business

FATHER 12. Name Jacanty Spioch  
13. Birthplace Austria

MOTHER 14. Maiden name Sophia Jarasevicz  
15. Birthplace Germany

16. Informant Charles M. Spioch  
Address 3546 Horton Ave., Balto., Md.

17. Burial Burial Date thereof Dec. 28, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Holy Cross Cemetery  
Location Anne Arundel Co., Maryland

18. Funeral director B. C. Harle  
Address 121 E. West St., Baltimore, Md.

19. Dec. 25, 1946  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1946 at 1:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5, 1946 to Dec. 25, 1946 and that I last saw him alive on December 25, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 6 mos.

Due to Tubercle Bacilli

Due to

Other conditions Myocardial Insufficiency Unknown  
(Include pregnancy within 3 months of death)

Major findings of operations No operation  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer m.d. M. D. or other

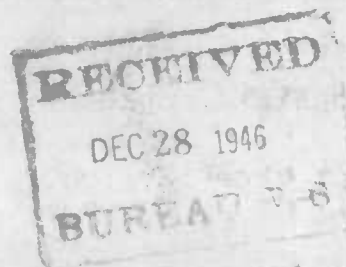
Address Mount Wilson, Md. Date signed 12/25/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Earl T. White  
Registral  
Rec'd 12-27-46



1-25

2-320-1-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-a)

## CERTIFICATE OF DEATH

11871

Reg. Dist. No. 381

### 1. PLACE OF DEATH:

County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution 509 Wilton Road  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) 8 yrs.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Towson Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 509 Wilton Road  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR No

### 3. (a) FULL NAME

Henry Hollowell Stabler

### 3. (b) Social Security Number

None

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Bessie Taylor Reid Stabler

6(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 4, 1856

8. AGE: Years 90 Months I Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace SANDY SPRING, MD.  
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business \_\_\_\_\_

FATHER 12. Name CHARLES STABLER

13. Birthplace MARYLAND.

MOTHER 14. Maiden name SARAH KIRK

15. Birthplace MARYLAND.

16. Informant MR. A. DOUGLAS STABLER

Address 1316 EUTAW PLACE.

17. BURIAL Date thereof 12/23/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory FRIEND'S MEETING BURIAL GROUNDS

Location SANDY SPRING, MARYLAND.

18. Funeral director WILLIAM E. TICKNER & SON'S

Address NORTH & PENN. AVES. BALTO., MD.

19. Date rec'd by registrar 12/23/46

Registrar [Signature]

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 19 46, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_, and that I last saw him \_\_\_\_\_

Immediate cause of death Chronic arterio-sclerotic disease

Due to Arteriosclerosis

Due to Senile changes

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE Rollin C. Hudson MD DME

Address Towson 4 Md

M. D. or other \_\_\_\_\_

Date signed 12/21/46.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-25-2-380-1-10



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

11872

## 1. PLACE OF DEATH

County

Balto.

Village or City

Essey 21

No.

Registration Dist. No.

440

St.

Ward

Length of residence in city or town where death occurred

yrs.

9

(If death occurred in a hospital or institution, give its NAME instead of street and number)

mos.

ds.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

Ann Danilla Stely.

(a) Residence: No.

399 Edgewater apt.

Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Fem.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year)

Oct 22/1946

7. AGE

Years

Months

Days

If LESS than

1 day, hrs. or min.

2

9

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BDDKKEEPER, etc.

None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

FATHER

13. NAME

Daniel H. Stely

14. BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

MOTHER

15. MAIDEN NAME

Lucille Eomer

16. BIRTHPLACE (city or town) (State or country)

Md.

17. INFORMANT

Daniel H. Stely

(Address)

Essey, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place

Hyattsville, Md.

Date

Jan 2, 1947

19. UNDERTAKER

(Address)

Francis Bosch, phone

Hyattsville, Md.

20. FILED

Dec 31, 1946, Dan H. Stely

Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Dec 31, 1946

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY, That I attended deceased from

Dec 31, 1946, to Dec 31, 1946

I last saw h. alive on

Dec 31, 1946

19

; death is said

to have occurred on the date stated above, at 4 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Suffocation

Date of onset

Immediate

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of Injury

19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Suffocation

Nature of injury

Concussion over head

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Dr. M. J. M. M. M.

(Address)

Dept. of Medicine

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
------------	-------------

## Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore <sup>96</sup>CERTIFICATE OF DEATH <sup>BC</sup>

11873

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 hours 45 minutes  
 Hospital, institution, or street address where death occurred:  
Veterans Hospital, Fort Howard, Maryland  
 How long in hospital or institution? 3 hours 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County .....  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3601 Mt. Pleasant Ave.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW II

## 3. (a) FULL NAME

CYRUS JACOB STEWART

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of ~~husband~~ or wife Genevieve Stewart  
 6. (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 3-31-08

8. AGE: Years 38 Months 8 Days 5 If less than one day ..... hrs. .... min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation Charger BSCO

11. Industry or business

FATHER 12. Name Cyrus Stewart

13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Martin

15. Birthplace Maryland

16. Informant Registrar's Office, Clinical Records

Address Veterans Adm., Ft. Howard, Maryland

17. Burial Date thereof Dec 10/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Schwartz's home

Location Baltimore

18. Funeral director Philip's Moving Sons

Address 2024 Collins St

19. 12/17 46 A. H. Hedrick  
 (Date rec'd by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 19 46 at 1:45 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6 19 46 to December 6 19 46 and that I last saw him alive on December 6 19 46

Immediate cause of death Rupture of aneurysm of anterior cerebral artery DURATION 1 mo.

Due to

Due to Hypertension 1 year plus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Morris E. Krucoff, M.D.  
 M.D. or other

Address V. A. Ft. Howard, Md. Date signed 12/6/46

Trans. 2  
E.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

11874

Reg. Dist. No. 44

1. PLACE OF DEATH:  
County Baltimore  
City or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Fort Howard, Maryland  
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2466 Keyway  
(If rural, give LOCATION)  
2(a) If veteran, name war W.W.I.

## 3. (a) FULL NAME

3 BERNARD F. STORCK

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Helen Storck  
6. (c) If alive, give age 44 years  
7. Birth date of deceased (mo., day, yr.) 10/20/1890  
8. AGE: Years 56 Months 2 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)  
10. Usual occupation Retired  
11. Industry or business  
12. Name Edmund C. Storck  
13. Birthplace Baltimore, Maryland  
14. Maiden name Mary E. Meisel  
15. Birthplace Baltimore, Maryland

16. Informant Registrar's Office, Clinical Records  
Address Fort Howard, Maryland  
17. Burial Date thereof Dec 27-46  
(Burial, cremation, or removal, Which) (month) (day) (year)  
Cemetery or crematory Holy Redeemer  
Location Baltimore Md.  
18. Funeral director Ellsworth Armagost  
Address 3911 Liberty Heights Ave  
19. Dec. 26 19 46 A. G. H. H. H.  
(Date of death) (Year) (Month) (Day) (Time)  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 24, 19 46, at 6:55am  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22, 19 46, to December 24, 19 46, and that I last saw him alive on December 24, 19 46.

Immediate cause of death Coronary Occlusion, acute DURATION Sudden  
Due to Heart Disease: 10 days  
Coronary Arteriosclerosis, Anginal plus  
syndrome  
Due to \_\_\_\_\_  
Other conditions Hypertension, arterial 2-1/2  
(Include pregnancy within 3 months of death) yrs. plus

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE R. M. Cullison M.D. or other  
R. M. CULLISON, M.D. CLIN. DIR.  
Address VA: HOSP., Ft. Howard, Md. Date signed 12-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

11875

581

## 1. PLACE OF DEATH:

County Balto.City or town Anneslie  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Anneslie  
(If outside city or town limits, write RURAL and give nearest town)Street No. 517 Mursdock Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie J. Strickler

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

Harry S. Strickler

7. Birth date of deceased (mo., day, yr.)

Jan 14, 1877

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

69

hrs.

min.

9. Birthplace

York Co. Pa.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Jacob Bentzel

13. Birthplace

Pa.

MOTHER

14. Maiden name

Sarah Lentz

15. Birthplace

Pa.

16. Informant

Mrs. James R. Thompson

Address

517 Mursdock Rd.

17.

Burial

Date thereof

Dec 7, 1946  
(month) (day) (year)

Cemetery or crematory

Salmon

Location

Slaver Pa.

18. Funeral director

Chenoweth & Sons

Address

3615-17 Chestnut Ave.

19.

12-45

19

46

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1946, at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 21, 1944 to Dec. 4, 1946and that I last saw her alive on Dec. 4, 1946

Immediate cause of death

Adeno Carcinoma of Uterus

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. G. Gole

M. D. or other

Address 6014 York RoadDate signed 12-4-46







# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

## CERTIFICATE OF DEATH

11877

Reg. Dist. No. 381

### 1. PLACE OF DEATH:

County Balto  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution? 8 MO

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Balto

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 6028 Old Harford Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

MARY T SUTTON

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

B.(b) Name of husband or wife John Sutton

7. Birth date of deceased (mo., day, yr.) Sept 16, 1876 8.(c) If alive, give age years

8. AGE: Years 70 Months 3 Days 22 If less than one day hrs. min.

9. Birthplace Md.  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Robert Pennington

13. Birthplace Md.

14. Maiden name

15. Birthplace

16. Informant Mr. Edwin Sutton

Address Home road apt. 206

17. Burial, cremation, or removal (Which?) Burial Date thereof Dec 31-46 (month) (day) (year)

Cemetery or crematory Schrensherry

Location Schrensherry rd

18. Funeral director Charles E. Cross

Address Baltimore, Md.

19. Date rec'd by registrar Dec 30 46 Registrar W. J. [illegible]

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 28<sup>th</sup> 1946, at 10<sup>00</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15<sup>th</sup> 1946 to Dec 28 1946  
and that I last saw him alive on Dec 28 1946

Immediate cause of death

Bulbar Paralysis DURATION 10 days

Due to General Arteriosclerosis

Due to Chronic Endocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

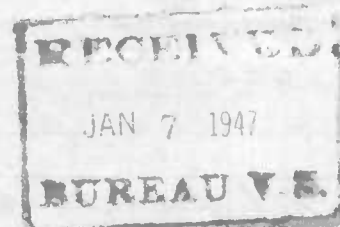
23. SIGNATURE Daniel J. [illegible] M. D. or other

Address Towson 4 Md Date signed 1/30/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

1946  
70

2-380 - 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *301*

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Week  
 Hospital, institution, or street address where death occurred:  
Rev. Opitz Home  
 How long in hospital or institution? 1 Week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2850 W. Lanvale St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \*\*\*\*\* ✓

## 3. (a) FULL NAME

Mary J. Swann

## 3. (b) Social Security Number

\*\*\*

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife James M. Swann

8. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

April 13, 1860

## 8. AGE:

Years

86

Months

8

Days

3

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation House Wife11. Industry or business Home12. Name J. Franklin Smith13. Birthplace Virginia14. Maiden name Julia A. Payne15. Birthplace Virginia16. Informant Mr. J. Payne SmithAddress 2850 W. Lanvale St.17. Burial Date thereof 12/18/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory WesternLocation Baltimore Md.18. Funeral director Geo. W. LittleAddress 2700 Edmondson Ave.19. 12/17 46 Registrar  
(Date recd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1946 19\_\_\_\_ at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 7 1946, to Dec 15 1946  
and that I last saw him alive on Dec 15 1946

Immediate cause of death

Chronic Endocarditis

DURATION

5 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE Isaac C. Dickson

M. D. or other

Address 3053 W. North Ave. Date signed Dec 16-46

3055 W. North Ave.

11/14/45

WILLIAM C. ELLIOTT  
W. C. ELLIOTT  
W. C. ELLIOTT

11/14/45

W. C. ELLIOTT

W. C. ELLIOTT

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

11879

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Turners Station  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 yrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md. County... Baltimore  
 City or town... Turner's Station  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3 Patapisco Ave.  
 (If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Steve Toth

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

September 21, 1887

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

59222

hrs. min.

9. Birthplace

Hungary  
(Town, county, and state)

10. Usual occupation

Machanist

11. Industry or business

FATHER

12. Name

Joseph Toth

13. Birthplace

Hungary

MOTHER

14. Maiden name

Mary

15. Birthplace

Hungary

16. Informant

Mrs. Vera Mack

Address

3 Patapisco Ave., Turner's Station

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Sacred Heart

Location

German Hill Road

18. Funeral director

Roland L. Fisher

Address

2112 Dundalk Ave.

19.

(Date rec'd by registrar)

12/15/46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 12<sup>th</sup> 1946 at 10:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
September 1946 to Dec 13<sup>th</sup> 1946  
 and that I last saw him alive on Dec 1<sup>st</sup> 1946

Immediate cause of death

septicemia mellitus

DURATION

3 1/2 yrs.

Due to

Due to septicemic gangrene of right foot 6 mo.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

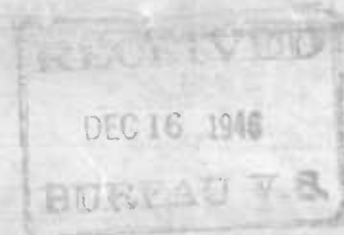
J. H. Thomas MD.  
Turner's Sta md Date signed 12/13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Pai



1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

## CERTIFICATE OF DEATH

11880

Reg. Dist. No. 330

## 1. PLACE OF DEATH:

County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 63 yrs

Hospital, institution, or street address where death occurred:

Reisterstown Road Owings MillsHow long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)Street No. Reisterstown Rd  
(If rural, give LOCATION)2(a) If veteran, name war No

## 3. (a) FULL NAME

John H. Turnbaugh Jr

## 3. (b) Social Security Number

078-05-1120

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Edna May Turnbaugh

7. Birth date of

deceased (mo., day, yr.)

August 2 18836. (c) If alive, give age 58 years

8. AGE:

Years 63Months 4Days 26

It less than one day

.....hrs. ....min.

9. Birthplace

Owings Mills-Balto Co-Md

(Town, county, and state)

10. Usual occupation

Shop worker-Balto Transit Co

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

It

MOTHER

14. Maiden name

It

15. Birthplace

It

16. Informant

Mrs Edna May Turnbaugh

Address

Owings Mills Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec 31 1946  
(month) (day) (year)

Cemetery or crematory

Pleasant Grove Cemetery

Location

Boring Md

18. Funeral director

Wm Berryman & Sons

Address

Reisterstown Md19. Dec - 30 - 19 46

(Date rec'd by registrar)

Mary B. E. Linc

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

December 28 1946 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-28-1946 to 12-28-1946and that I last saw him in alive on that same date 19 46

Immediate cause of death

Heart attack

DURATION

Instant

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Suicide Date of 12-28-46

Where did injury occur?

Average Public Balto, Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Home

Means of injury

Heart attack Injured at work? No

23. SIGNATURE

Dr. D. D. Caples, M.D.

M. D. or other

Address

Reisterstown, Md Date signed 12-30-46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

SIGNATURE

NAME OF PHYSICIAN

NAME OF REGISTRAR

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

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RECEIVED

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11881

Reg. Dist. No. 301

## 1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? About 1 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AA. B.City or town Orchard Beach  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

August Wagner

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Late Ellis Wagner

## 8. (c) If alive, give age. \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

Jan 23 - 1874

## 8. AGE:

72 Years10 Months26 Days

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 8. Birthplace

Baltimore Md  
(Town, county, and state)

## 10. Usual occupation

Retired ironworker

## 11. Industry or business

R.R. Shops

## FATHER

## 12. Name

Conrad Wagner

## 13. Birthplace

Germany

## MOTHER

## 14. Maiden name

Mary Reichtlitner

## 15. Birthplace

Germany

## 16. Informant

Mr August J Wagner

## Address

501 Hutton Ave. Baltimore

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12-21-46  
(month) (day) (year)

## Cemetery or crematory

London Park Cem

## Location

Baltimore Md

## 18. Funeral director

Geo. E. Boyer Jr

## Address

1512 Hollins St

## 19.

12-25 - 46  
(Date rec'd by registrar)46Harold Rupp

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Dec 19 1946 at 5:15 P. M.

## 21. I CERTIFY that death occurred on the date stated; that I attended deceased from

Nov 20 1945 to Dec 19 1946and that I last saw him alive on Dec 19 1946

## Immediate cause of death

Cerebral hemorrhage

## DURATION

2 days

## Due to

Hypertensionunknown

## Due to

## Other conditions

Arteriosclerosisunknown

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

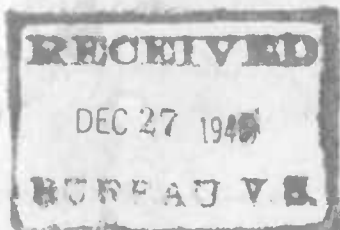
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

## Means of injury

Injured at work? \_\_\_\_\_

## 23. SIGNATURE

J. M. Hervey M.D.  
Retired 28-7-46 M. D. or other  
205 E. Bay View Ave Date signed 12/20/46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

1188301

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year, 3 months, 28 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 1 year, 3 months, 28 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3428 Roland Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lawrence Wagner

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife None  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 13, 1887  
 8. AGE: Years 59 Months 8 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore Maryland  
 (Town, county, and state)  
 10. Usual occupation Clerk  
 11. Industry or business Business  
 12. Name William H. Wagner  
 13. Birthplace England  
 14. Maiden name Alice George  
 15. Birthplace England

16. Informant Hospital Records  
 Address Catonsville, 28, Md.  
 17. Burial Date thereof See 24/46  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Landon Park  
 Location Federal Road  
 18. Funeral director Chenoweth & Donovan  
 Address 3615-17 Chestnut Ave  
 19. 12/23 46 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH December 21, 1946 19\_\_\_\_ at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 23, 1945 19\_\_\_\_ to December 21, 1946  
 and that I last saw him alive on December 21, 1946 19\_\_\_\_

Immediate cause of death Acute myocardial failure  
 DURATION 6 hours

Due to Acute perforation of a chronic gastric ulcer  
 DURATION 24 hours?

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations Obstruction by malleable mass in the colon  
 Date of op. 12/21/46

Autopsy results As above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Henry C. A. Mead, M.D.  
 Henry C. A. Mead, M.D. M. D. or other  
 Address Catonsville, 28, Md. Date signed 12/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 820

## CERTIFICATE OF DEATH

11883



Reg. Dist. No. 330

1. PLACE OF DEATH:  
County Balto.  
City or town Near Cwings Mills  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md. County Balto.  
City or town Cwings Mills  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Pleasant Hill Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war .....

## 3.(a) FULL NAME

Addie B. Walls

## 3.(b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Morris G. Walls  
6.(c) If alive, give age ..... years  
7. Birth date of deceased (mo., day, yr.) July 14, 1879  
8. AGE: Years 67 Months 5 Days ..... It less than one day ..... hrs. .... min.

9. Birthplace Carroll Co.  
(Town, county, and state)  
10. Usual occupation Housework  
11. Industry or business  
12. Name George Collins  
13. Birthplace Carroll Co.  
14. Maiden name Carrilla Boardley  
15. Birthplace Howard Co.

16. Informant Mrs. Elsie Collins  
Address Cwings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec. 17, 1946  
(month) (day) (year)  
Cemetery or crematory Johnsville  
Location Carroll Co.

18. Funeral director J. F. Eline & Sons  
Address Reisterstown, Md.

19. Dec-17-1946 Mary B. Eline  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1946, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1946 to Dec 14 1946 and that I last saw him alive on Dec 14 1946

Immediate cause of death Cerebral Hemorrhage DURATION 4 hrs.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations none

..... Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE D. D. Caples M.D. med. Exam

Address Reisterstown, Md. M. D. or other

Date signed 12-16-46



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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

11884

P

Reg. Dist. No. 4K

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 257 Da ys  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
How long in hospital or institution? 257 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County 40  
City or town Glen Bernie  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. #3 Craig Highway  
(If rural, give LOCATION)  
2.(a) If veteran, name war WW-I ☒

### 3. (a) FULL NAME

JOHN G. WALTER

### 3. (b) Social Security Number

215-07-4404

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
-----------------------	----------------------------------	----------------------------------------------------------------

6. (b) Name of husband or wife Widowed  
6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 1-3-88

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>11</u>	<u>5</u>	_____ hrs. _____ min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Walter  
13. Birthplace Maryland

MOTHER 14. Maiden name Louise Reece  
15. Birthplace Maryland

16. Informant Registrar's Office, Clin. Records,  
Address Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial Date thereof Dec 18, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Funeral home Portage & Offels for  
Cemetery or crematory Laurel Park  
Location Laurel Park

18. Funeral director Wm. Roderick  
Address 4200 Belair Rd

19. 12/9 x6 A. W. Hedrich  
(Date rec'd by registrar) (Signature) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1946, at 7:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26, 1946, to December 8, 1946  
and that I last saw him alive on December 8, 1946

Immediate cause of death	DURATION
<u>Coronary Arteriosclerosis</u>	
<u>Anterior descending artery with</u>	
<u>thrombosis infarction left</u>	
<u>ventricle</u>	<u>Sudden</u>
Due to	
Other conditions <u>Old Coronary thrombosis with</u>	
<u>infarction of left ventricle</u>	<u>1 Year</u>
<u>Diabetes</u> (Include pregnancy within 3 months of death)	<u>1 Year</u>
<u>Arteriosclerotic gangrene left leg</u>	
Major findings of operation <u>with amputation</u>	<u>6 Mos.</u>
Date of op.	

Autopsy results Substantiated above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. B. French  
A. B. FRENCH, M. D. M. D. or other  
Address V. A. Ft. Howard, Md. Date signed 12-8-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

## CERTIFICATE OF DEATH

Reg. Dist. No. 11885 3/0

## 1. PLACE OF DEATH:

County Balto.City or town Larchmont Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty BaltoCity or town Larchmont

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2315 Birch Drive

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Chester Read Wells

## 3. (b) Social Security Number

216-10-4846

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Elsie R. Wells

..... 5. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 5 1888

## 8. AGE:

Years

58

Months

4

Days

16

If less than one day

..... hrs. .... min.

## 9. Birthplace

Elkridge Md

(Town, county, and state)

## 10. Usual occupation

Field Manager

## 11. Industry or business

General Motors

FATHER

## 12. Name

Jacob R. Wells

## 13. Birthplace

Baltimore Co Md

MOTHER

## 14. Maiden name

Ida M. Rodgers

## 15. Birthplace

Maryland

## 16. Informant

Elsie R. Wells

## Address

2315 Birch Drive

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec 24 1946

(month) (day) (year)

## Cemetery or crematory

Woodlawn

## Location

Woodlawn Md

## 16. Funeral director

## Address

4204 Ridgewood Ave

## 19.

(Date rec'd by registrar)

12/23/46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 21 December 19 46 at 2:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

14 October 19 46 to 21 Dec. 19 46and that I last saw him alive on 20 December 19 46Immediate cause of death Carcinoma of the rectum and  
pyelonephritis

## DURATION

1 year2

Due to

Due to

Other conditions

Diabetes melitus12 year

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of the rectum

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Douglas Lockard  
M. D. or other

Address

2322 1st StDate signed 23 Dec 1946

802 Cathedral Lockhardt

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

## CERTIFICATE OF DEATH

Reg. Dist. No.

11886381

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 years

Hospital, institution, or street address where death occurred:

33 Allegheny Avenue

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 33 Allegheny Avenue

(If rural, give LOCATION)

None

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Clara May Whittle

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife.....

..... 6.(c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

June 21, 1866

## 8. AGE:

80

Years

Months

5

Days

19

It less than one day

..... hrs. .... min.

## 9. Birthplace.....

Towson, Maryland

(Town, county, and state)

## 10. Usual occupation.....

Homemaker

## 11. Industry or business.....

At Home

## FATHER

## 12. Name.....

Samuel N. Whittle

## MOTHER

## 13. Birthplace.....

Maryland

## 14. Maiden name.....

Georgeanna Hagle

## 15. Birthplace.....

Maryland

## 16. Informant.....

Miss Annie Phipps

## Address.....

33 Allegheny Ave., Towson, Md.

## 17.

Burial

Date thereof.....

Dec. 12, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory.....

Govans Presbyterian Cem.

## Location.....

Baltimore, Maryland

## 18. Funeral director.....

## Address.....

Towson, Maryland

## 19.

(Date rec'd by registrar)

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## MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 10, 46, 3:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19.46 to Dec. 10, 19.46

and that I last saw him alive on December 9, 19.46

Immediate cause of death.....

Arterio-sclerotic hyperextension  
Myocardial infarction

## DURATION

3 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

R. P. Sellman MD

M. D. or other

Address.....

600 Baltimore Towson Md

Date signed Dec 10 1946

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

133a

11774

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Baltimore  
City or town Reisterstown  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
City or town Reisterstown Ward No.  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 52 Bond Ave.  
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

### 3. (a) FULL NAME

ROBERT PAUL WILLIAMS

### 3. (b) Social Security Number

212-05-0734

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1908

8. AGE: Tears Months Days If less than one day

38 2 12 hrs. min.

9. Birthplace Howard Co., Md.  
(Town, county, and state)

10. Usual occupation Cook

11. Industry or business

12. Name Mathias Williams

13. Birthplace Md.

14. Maiden name Clara Garrett

15. Birthplace Md.

16. Informant Rev. Mathias Williams

Address 52 Bond Ave.

17. Burial Date thereof 12-12-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West Liberty Cem.

Location West Liberty, Howard Co., Md.

18. Funeral director Mrs. Frances A. Homsley

Address 578 W. Biddle St.

19. 12-10-46 19 46 Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 19 46, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-29 19 46, to 12-8 19 46,  
and that I last saw him alive on 12-8-46 19

Immediate cause of death

Uremia  
Contracted bladder which  
was removed at Johns Hopkins  
Hosp in 1933.

Due to Probably due to a pyelitis.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

### DURATION

10 days

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples, Jr. D M. D. or other

Address Reisterstown, Md. Date signed 12-9-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 372

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs, 9 months  
 Hospital, institution, or street address where death occurred:  
Masonic Home, Cockeysville Md  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1213 E. North Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.

## 3. (a) FULL NAME

Mrs. Bertha M. Woods

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 8. (b) Name of husband or wife Charles Henry Woods  
 8. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Nov. 1 - 1873  
 8. AGE: Years 73 Months 1 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Centerville Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Henry A Collins

13. Birthplace Baltimore Md

14. Maiden name Sarah E. Cook

15. Birthplace Baltimore, Md

16. Informant Laura M. Schroeder

Address Masonic Home, Cockeysville

17. Burial, cremation, or removal. Which? Burial Date thereof 12 - 27 - 46  
 (month) (day) (year)

Cemetery or crematory Linden Park

Location Next to husband

18. Funeral director Wm. Cook

Address St. Paul & Preston St

19. Dec 24 19 46 L. M. Schroeder  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23rd 19 46 at 7:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 46 to Dec 23 19 46  
 and that I last saw him alive on Dec 23 19 46

Immediate cause of death acute congestive heart failure

Due to arteriosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Ante mortem \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

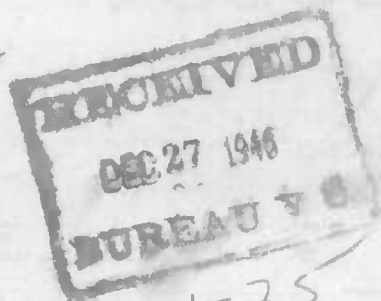
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Walter T. Kees M.D.

Address Cockeysville, Md Date signed 12/23/46



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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

## CERTIFICATE OF DEATH

11888

Reg. Dist. No. 311

### 1. PLACE OF DEATH:

County Baltimore

City or town Hebbville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Harriett E. Zimmerman

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Benj. F. Lee Zimmerman

6. (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) September 13, 1874

8. AGE:

Years

Months

Days

If less than one day

72

3

7

hrs.

min.

9. Birthplace Baltimore County, Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

MOTHER  
FATHER

12. Name Joshua Meekins

13. Birthplace Baltimore County, Md.

14. Maiden name Kazar Smith

15. Birthplace Baltimore County, Md.

16. Informant Mr. Lee Zimmerman

Address Hebbville, Md.

17. Burial Date thereof Dec. 23, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olive Cemetery

Location Randallstown, Md.

18. Funeral Director Holmes & Lenoire

Address 4510 Liberty Heights Ave.

19. Dec 21 19 46  
(Date rec'd by registrar)

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Hebbville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 19 46 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 10 19 46, to Dec 20 19 46

and that I last saw her alive on Dec 19 19 46

Immediate cause of death

Consumption of heart 10 days

Due to Consumption of heart 5 years

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

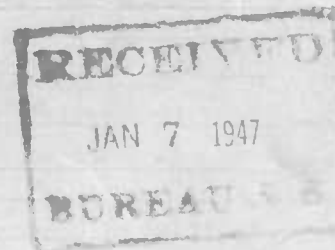
23. SIGNATURE R. E. Smith M. D. or other

Address 4509 Liberty Hgts. Ave. Date signed Dec 21

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

2-310 - 2-10